

State Opioid Response 2 Grant Evaluation: Final Report

September 30, 2020 – September 29, 2022

Portland State UNIVERSITY

Prepared by:

Christine Cooper
Ashley Dupee
Carrie Furrer
Isabella Ginsburg
Nicole Lauzus
Yumi Lee
Katie Shammel

Center for Improvement of Child & Family Services
Portland State University

Portland State University Contact:
Carrie Furrer cfurrer@pdx.edu

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Oregon Health Authority

Health Systems Division

Oregon Health Authority

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Oregon Health Authority Contact:
Kelsey Smith-Payne
KELSEY.SMITHPAYNE@dhsoha.state.or.us

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Introduction

Oregon's State Opioid Response Grant

In September 2020, the State of Oregon received funding for a second cohort of State Opioid Response (SOR2) grantees from the Substance Abuse and Mental Health Services Administration (SAMHSA). The purpose of SOR2 funding was to address the opioid overdose crisis in Oregon by increasing access to FDA-approved medications for the treatment of opioid use disorder (OUD), and supporting the continuum of prevention, harm reduction, treatment, and recovery support services for OUD and other substance use disorders (SUD).

The Oregon Health Authority (OHA) administers the SOR2 grant in Oregon (funding period: September 30, 2020 – September 29, 2022). OHA's SOR2 strategic plan had nine key initiatives working toward five strategic goals, as shown in Table 1 (SUD = substance use disorder; MAT = medication assisted treatment).

Table 1: Oregon's SOR2 Grant Simplified Logic Model

Inputs	Initiatives	Strategic Goals
• Award funds to grantees • Administer grant (e.g., technical assistance, compliance monitoring) • Develop and execute contracts • Ensure prioritized SUD systems needs are addressed • Attend to health equity based on known SUD system disparities	Increase access to MAT	Increase access to SUD treatment
	Increase access to Stimulant Use Disorder treatment	
	Increase access to intervention & long-term recovery	Increase access to SUD recovery support services
	Expand school-based primary prevention programs for students, staff & families	Expand SUD prevention & early intervention
	Reduce opioid prescriptions/expand overdose prevention	
	Expand naloxone distribution, education & technical assistance statewide	Increase access to harm reduction & overdose prevention
	Increase screening and treatment for infectious diseases	
	Reduce stigma associated with MAT	SUD workforce development
	Expand SUD workforce	

Client Outcome Data

SOR2 funded grantees and programs completed bi-annual progress reports between September 30, 2020 and September 29, 2022:

- Year 1 mid-year (September 30, 2020 – March 31, 2021)
- Year 1 end-of-year (April 1, 2021 – September 29, 2021)
- Year 2 mid-year (September 30, 2021 – March 31, 2022)
- Year 2 end-of-year (April 1, 2022 – September 29, 2022)

Appendix A includes the unduplicated counts of clients receiving treatment and recovery support services, as well as overdose reversals during the 2-year SOR2 funding period. RMC Research's end-of-grant report, which includes an analysis of Government Performance Reporting Act (GRPA) client outcome data and a final Naloxone Report, is include in Appendix B.

Overview of SOR2 Evaluation

The OHA contracted with Portland State University (PSU) to evaluate the overall impact of SOR2 funding. Our work at PSU has the explicit goal of promoting social justice for individuals and communities through equity-driven evaluation and recommendations for addressing root causes, which aligns with OHA's definition of health equity.[1] The evaluation had three core components: (1) successes and challenges associated with implementation and sustainability, (2) collaboration efforts to support SOR2-funded activities, and (3) impact on expanding access to SUD services and supports.

Special Projects

In collaboration with OHA partners, PSU also completed three special projects within the scope of the overall impact evaluation: (1) Medication Assisted Treatment Expansion, (2) Workforce Development, and (3) Infectious Disease Protocols. We describe each of these in more detail:

Medication Assisted Treatment Expansion Project

PSU conducted an evaluation of the SOR2-funded medication assisted treatment (MAT) expansion. The purpose of the MAT evaluation was to document the implementation of MAT services within eight agencies, and examine the impact that SOR2-funded MAT services had on people struggling with Opioid Use Disorder (OUD). See Appendix C for the evaluation report and Appendix D for a summary of lessons learned and recommendations for future MAT expansion.

Workforce Development Project

PSU conducted an evaluation of the SOR2 grant's impact on Oregon's SUD workforce (referred to as the workforce evaluation). This work included two follow up surveys for participants of Dr. Janice Crawford's Education Toward CADC (ETC) program and the 40-hour Core Adult Addictions Peer Support training sponsored by Mental Health and Addiction Certification Board of Oregon (MHACBO). Both programs prepared participants to advance towards professional certifications. The workforce evaluation investigated participants' progress toward certification, as well as how the training programs impacted the participants' career trajectories. The Core Peer Training was offered in Spanish and English, as was the follow up survey. See Appendix E for a copy of the ETC Follow Up Survey, Appendix F for the Core

[1] https://www.oregon.gov/oha/oei/pages/health-equity-committee.aspx

Peer Training Follow Up Survey, and Appendix G for *Encuesta de seguimiento de la capacitación básica entre pares* (Core Peer Training Follow Up Survey).

See Appendix H for the *Education Toward CADC Follow Up Survey Report* and Appendix I for the *Core Peer Training Follow Up Survey Report*. Similarly, PSU had the Core Peer Training Follow Up Survey Report translated into Spanish to improve access to the evaluation findings for all participants (see Appendix J for the *Informe de la encuesta de seguimiento de la capacitación básica entre pares*). PSU also designed two infographics summarizing key findings to share with training participants; the infographic summarizing the Core Peer Training survey results was also translated into Spanish. See Appendix K for the Education Toward CADC (ETC) Follow Up Survey infographic, Appendix L for the Core Peer Training Follow Up Survey infographic, and Appendix M for the *Informe de la encuesta de seguimiento de la capacitación básica entre pares* infografía.

Infectious Disease Protocols Project

PSU developed a survey and follow-up interview protocol to better understand how MAT grantees were screening and testing for infectious diseases. The purpose of this work was to understand what is working well, areas for improvement, and support needed. PSU organized the survey according to a medical cascade of care model (e.g., prevention, screening, testing, diagnosis, linking to care, treatment, treatment retention, and sustained virologic response). Topics also covered facility needs and measures to support sustainability (e.g., trainings, funding sources) and key agency characteristics (e.g., agency type, geographic location). A copy of the infectious disease screening survey and follow-up interview questions is available from OHA upon request. See Appendix N for the key findings and recommendations from the Infectious Disease Protocols project.

Organization of this Report

This report is organized in the follow three sections according to the evaluation's core components:

- Implementation of SOR2-funded Activities summarizes the successes and challenges grantees experienced as they implemented SUD treatment and recovery services, harm reduction and overdose prevention services, workforce development activities, and upstream prevention efforts.
- Collaboration: A Pathway and an Outcome is an analysis of how SOR2 funding encouraged collaborative partnerships, thereby increasing connectivity within Oregon's SUD system, and created a pathway to expand and improve service delivery through collaboration.
- SOR2 Impact Evaluation assesses and summarizes the available evidence of SOR funding impact on the SOR2 strategic goals to increase access SUD treatment, SUD recovery support services, SUD prevention and early intervention, access to harm reduction and overdoes prevention supplies and services, and to expand Oregon's SUD workforce.

The last two sections include key findings from the overall SOR2 evaluation, as well as recommendations for future investments in Oregon's SUD system.

Implementation of SOR2-funded Activities

Implementation is defined as "a specified set of activities designed to put into practice an activity or program."[2] It is an iterative process that unfolds over time and, to be successful, the activities should be continuously revisited and used to make improvements.[3] The National Implementation Research Network (NIRN) offers multiple frameworks to support implementation. For this evaluation, PSU used the NIRN Implementation Drivers Framework[4] as an organizing structure to summarize the implementation successes and challenges that grantees described in their semi-annual progress reports. The framework includes three drivers that work together to create the infrastructure and conditions needed to implement and sustain an innovation (e.g., program, intervention, practice) as intended:

1. ***Competency drivers***, which support the organization's ability to carry out an innovation, include staff selection/hiring, training, and coaching.
2. ***Organization drivers***, which create a supportive environment for carrying out an innovation, include systems intervention (e.g., collaboration with external partners), facilitative administration (e.g., internal policies and structures), and decision support data systems (e.g., collecting and analyzing outcome and fidelity data).
3. ***Leadership drivers*** refer to strategies needed to guide the innovation, support the organization, and address challenges as they arise.

The implementation drivers are integrated and compensatory such that a lack of skills, abilities, or conditions in one driver can be *compensated* for by another driver.[5] For example, if an organization is unable to hire someone with specific credentials, training or upskilling existing staff could compensate for the hiring challenge.

Impact of COVID-19 & Natural Disasters on Implementation

Nearly all grantees experienced challenges due to the COVID-19 pandemic, and the wildfires and ice storm that precipitated states of emergency across much of Oregon in 2020 and early 2021. These combined disasters interrupted training, planning, meetings, openings, outreach and collaboration efforts, conferences, and more. Despite these challenges, grantees were resilient and creative in their responses, and even described learning new ways to engage families in services and more economical ways to provide trainings using virtual platforms.

[2] Fixsen, D., Naoom, S., Blase, K., Friedman, R., & Wallace, F. (2005). *Implementation Research: A Synthesis of the Literature***.** Tamps, FL: University of South Florida, Louis de la Parte Florida Mental Health Institute, National Implementation Research Network.

[3] https://nirn.fpg.unc.edu/module-1/implementation-stages

[4] https://nirn.fpg.unc.edu/module-2/implementation-drivers

[5] *Ibid.*

Implementation Successes and Challenges

For this analysis, PSU reviewed SOR2 grantee progress reports submitted in the first year of funding (Year 1 mid-year and Year 1 end-of-year reports), as well as sustainability plans described in Year 2 mid-year progress reports. We summarized grantees' implementation activities within each of the following SOR2 strategic goal areas: Recovery Support Services, Workforce Development, Harm Reduction/ Overdose Prevention, SUD Treatment, and Upstream Prevention & Early Intervention. Many grantees conducted activities in multiple strategic goal areas (see Appendix O for a list of grantees and their strategic goal areas).

Recovery Support Services

Grantees providing recovery support services described implementation successes related to ***organization*** and ***competency*** drivers, including building supportive partnerships, program monitoring and improvement, and coaching and ongoing learning.

- **Building new partnerships.** According to the NIRN framework, the *systems intervention* implementation driver involves building external partnerships and structures within the larger SUD system to facilitate implementation, streamline services, and support sustainability. Grantees providing recovery services described partnerships with other organizations to develop referral pathways, improve their ability to provide culturally responsive services, and to connect with organizations doing similar work. For example, PRIME+ used the Basecamp platform to connect agency staff across counties. As another example, 4D Recovery provided technical assistance (TA) to support the development of two new culturally-specific, peer-led recovery organizations, Northwest Instituto Latino (NWIL) and Painted Horse Recovery. Moreover, grantees described mutually beneficial partnerships that supported the expansion of access to culturally-specific service and shared learning around grant execution and fiscal management.

- **Program monitoring and improvement.** The NIRN framework underscores the importance of ongoing program monitoring and improvement, and the *decision support data systems* driver refers to infrastructure that supports data-driven decision-making. Several grantees providing recovery support services used surveys and other methods to collect feedback from clients to assess the effectiveness of their services and identify areas for improvement. For example, Alano Club collected client data including satisfaction with services, current use of substances, engagement activities, and quality of life assessment.

Decision Support Data Systems Driver: PRIME+ and Comagine Health

In support of the implementation of PRIME+ in multiple counties, Comagine Health launched a data collection system called RecoveryLink, along with a quality assurance plan to ensure complete and accurate data entry. Program monitoring helped identify a challenge that some PRIME+ sites experienced in supervising peer support staff. In response, Comagine and OHA developed a process for having one PRIME+ site provide remote supervision for staff at other sites.

- **Coaching and ongoing professional learning**. The NIRN competency driver, *coaching,* promotes staff skills, abilities, and confidence. In addition to core trainings for newly hired staff, most recovery

support grantees described ongoing clinical supervision, coaching, "peer huddles to facilitate idea sharing [and] encouragement and support," and professional learning opportunities (e.g., SAMHSA Peer Competencies, harm reduction education, HIPAA requirements). For example, PRIME+ described holding Learning Collaborative sessions for peer support specialists, supervisors, and administrators, and integrated new sites as they joined and teams expanded.

Challenges were concentrated around NIRN ***competency*** drivers, particularly related to *selection* and *training*. Key issues included high turnover rates, recruiting and retaining diverse staff, background checks that created barriers for hiring and credentialing, and the need for additional training even for credentialed peers.

- **Hiring and staff retention.** Many grantees providing recovery support services described hiring challenges. Background checks created barriers for hiring and credentialing peers already on staff. Some grantees described challenges hiring diverse staff, particularly bilingual/bicultural staff. Grantees described working to increase revenue sources to adequately compensate peers and increase retention. Even with implementation support from Comagine Health, hiring was an issue for PRIME+ due to high turnover. To compensate for challenges with the *selection* driver, PRIME+ used *training* driver strategies – they developed training materials and online access to recorded trainings to expedite high quality training for new peers.

Selection Driver:
Northwest Instituto Latino (NWIL)

NWIL described how they overcame challenges in hiring the diverse staff they needed:

"*Through our deep connections in the Latinx community we have successfully hired 3 MHACBO [Mental Health & Addiction Certification Board of Oregon] certified Latinx staff who were not previously working as mentors. We were able to attract those employees by leading the market in base pay, providing full medical benefits, and providing culturally and linguistically specific supervision, on-boarding and training.*"

- **Staff Training.** In addition to the training need created by hiring challenges, as just described, many grantees providing recovery support noted that even credentialed peers needed ongoing training to better meet the needs of the communities they serve (e.g., immigration and translation services). Grantees also named additional training needs for computer and administrative skills, and the intensive training required to conduct GPRA interviews with clients.

Last, grantees providing recovery support services experienced challenges related to *facilitative administration* and *systems intervention*, both ***organization*** drivers. For example, 4D Recovery described experiencing issues around permitting for the construction of their second recovery center, and state contractual and procedural issues interrupted implementation of the PRIME+ data systems, RecoveryLink and Basecamp.

Workforce Development

SOR2 funding allowed workforce development grantees to expand their existing training programs and curricula to more individuals and, in some cases, priority populations (e.g., rural counties). Grantees

noted successes within the ***organization*** and ***competency*** drivers related to policies and procedures, and using data to train and improve services.

- **Assessing and aligning policies with values and goals.** The facilitative *administration* driver involves creating an environment conducive to implementing a new program. One workforce grantee drafted an implementation manual and held a series of meetings to adapt the program to specific departments within the agency, and train staff on the new procedures. Additionally, several grantees noted the need to explicitly name and operationalize their equity and anti-racism values to help ensure their integration in workforce development activities.

Facilitative Administration Driver: Oregon ECHO Network

The Oregon ECHO Network developed the following organizational statement that they are all working to operationalize:

"*As a project within the Oregon Rural Practice Based Research Network, Oregon ECHO Network is committed to building and sustaining a diverse, equitable, inclusive and anti-racist organization. We do so by evaluating how we develop and support our workforce, the partnerships we uphold and how we engage in community-partnered dialogue, research, coaching and education throughout Oregon.*"

- **Program monitoring and improvement.** All workforce development grantees collected data from participants to support ongoing improvement. For example, Dr. Janet Crawford's Education Toward CADC training gathered demographic and satisfaction data from participants to help improve training content and processes, and Project ECHO surveyed participants after each session to use feedback to "improve the program as [it's] offered."
- **Training and using data to train to fidelity.** Despite pandemic-related disruptions that required moving workforce development activities online, grantees reported conducting successful trainings. For example, Northwest Addiction Technology Transfer Center's (NW ATTC) online Contingency Management (CM) training with Oregon Recovery Treatment Center staff was described as a "pragmatic and efficient approach" likely to be continued with future opioid treatment providers. The NW ATTC training also included a training-to-criterion fidelity measure in which participants demonstrated 'acceptable' skill in each of six domains.

Overall, workforce development grantees described few barriers to implementation. However, there were a few challenges clustered around the ***organization*** drivers, *systems integration* and *facilitative administration*. For example, grantees faced challenges establishing subcontracts with other organizations and communicating with training participants when secure email platforms blocked grantee emails. Another example is when the Oregon Health Science University (OHSU) Tele-HCV program encountered delays in service provision due to a requirement for prior authorizations for HCV treatment. In response, OHSU staff partnered with OHA staff to present to the state's advisory Pharmacy and Therapeutics (P&T) Committee on the rationale for removing this requirement.

Harm Reduction/Overdose Prevention

Grantees providing harm reduction/overdose prevention services largely described successes related to ***organization*** drivers, particularly *systems intervention* and *facilitative administration* activities such as

building and strengthening partnerships, updating policies and internal processes, program monitoring and improvement, and securing resources and funding. For example:

- **Building and strengthening partnerships.** All grantees providing harm reduction/overdose prevention services described building new and strengthening existing partnerships. For some grantees (e.g., Drug Overdose Prevention Initiative), collaboration with other overdose prevention providers was a core goal. During a pandemic that limited outreach and relationship building, several grantees described the importance of leveraging existing community relationships to support the expansion of harm reduction services. As an example of building new partnerships, Max's Mission worked with local libraries to install naloxone boxes (NaloxBoxes) on the outside of their buildings. Another example is the grantees that worked with local jails and community justice organizations to expand naloxone distribution.

  Many grantees described efforts to build partnerships with culturally-specific organizations, with the goal of increasing equitable access to harm reduction/overdose prevention services, as well as to support them in providing culturally-responsive services. For example, Clatsop County worked with culturally-specific organizations to improve access to their syringe exchange program. Another example is that Brink Communications, supporting the implementation of Save Lives Oregon (naloxone clearinghouse), worked with NWIL, a Latine-specific recovery organization,[6] to adjust their "approach as needed to ensure Save Lives Oregon resonates meaningfully with brown-, and immigrant-led service organizations."

- **Assessing and aligning policies with values and goals.** In addition to building partnerships with culturally-specific organizations, Multnomah County described reevaluating their hiring processes with the goal of hiring staff with lived experience reflecting their target population.

- **Securing resources and additional funding.** A few grantees providing harm reduction/overdose prevention services secured additional funding and resources to counteract a lack of available harm reduction supplies. For example, Multnomah County was able to continue to procure and distribute naloxone during a shortage due to partnerships they developed with other organizations (see *Sustainability Planning* for more information about funding).

- **Program monitoring and improvement.** Most harm reduction/overdose prevention grantees described using data (e.g., client and/or staff feedback, community needs assessments) to improve services. One example is that Clatsop County responded to staff and community discomfort with administering injectable naloxone by increasing their purchasing of nasal Narcan.

Grantees detailed various implementation challenges associated with the ***organization*** and ***competency*** drivers, including community partnerships and support, funding availability, data collection, and staffing.

- **Community support and funding.** The Drug Overdose Prevention Initiative supported local public health authorities across Oregon in providing harm reduction services to reduce the number of overdose deaths and hospitalizations. In counties with less community support and funding for harm

[6] In this report we use the term "Latine" as a gender-neutral alternative to "Latino" that is more natural to pronounce when communicating in Spanish. We use the term "Hispanic" to refer to people who speak Spanish.

reduction, regional coordinators did additional outreach to counter misinformation and allotted additional time for identifying long-term, sustainable funding streams.

- **Burden of data tracking and collection.** As stated previously, many harm reduction/overdose prevention grantees collected data to support service improvement. A number of grantees also pointed out the burden that data collection puts on staff and community partners. For example, Comagine Health described how PRIME+ peer staff shouldered added burden when they were expected to track their distribution of harm reduction materials in RecoveryLink. After conferring with OHA, Comagine Health was able to minimize data collection to alleviate this burden. HIV Alliance also noted that they asked jails to complete a form when they distribute naloxone kits to individuals released from incarceration, but some had trouble completing the request and, in some cases, declined kits because of this extra burden. In response, HIV Alliance is considering updating their data collection policies to reduce burden on partners.
- **Difficulties with funding leading to staffing challenges.** One grantee identified staffing challenges due to insufficient funding. Clatsop County reported that funding for staffing was an ongoing barrier necessitating a reliance on "casual" staff who have a limited number of hours available to support harm reduction services. This drove a need for ongoing training of new staff, further straining resources, and interrupting relationship development with clients.

SUD Treatment

Grantees providing treatment services reported implementation successes centered on ***organization*** and ***competency*** drivers related to program monitoring and improvement, and external collaborations. Some of the most significant successes for treatment grantees were the creative solutions they implemented in response to challenges, most notably related to the ***organization*** drivers, *systems intervention* and *facilitative administration*.

- **Establishing policies and procedures.** Most treatment grantees described challenges creating new and adapting existing policies and procedures to manage billing (e.g., competing behavioral and medical health billing models) and to comply with health system regulations and confidentiality laws. Many grantees navigated these challenges by partnering with external organizations. For example, grantees housed in SUD/behavioral health settings described working with their regional Medicaid insurance coordinators (Coordinated Care Organizations, or CCOs) to develop policies and procedures that met medical billing requirements. Similarly, some grantees in medical settings encountered issues providing certain SUD services due to SUD-specific billing requirements and federal confidentiality regulations (42 CFR, part 2 pertaining to maintaining SUD records separately from medical records[7]).

Facilitative Administration Driver: Fora Health

Fora Health worked with their regional Medicaid coordinator to develop a BioPsychoSocial assessment that supported rapid MAT induction for clients and met medical reimbursement requirements.

[7] https://www.ecfr.gov/current/title-42/chapter-I/subchapter-A/part-2

The Oasis Center of Rogue Valley partnered with outside agencies to maintain SUD records separately and to provide services (e.g., peer support) "not supported through medical billing."

- **Program monitoring and improvement.** In general, treatment grantees described a flexibility and a focus on program improvement that enabled them to make procedural changes as needed. Several grantees reported having to update intake protocols and other procedures to better meet MAT clients' needs. For example, Fora Health developed internal training documents, integrated a new electronic health record (EHR) platform, and hired additional staff to improve the coordination of client transfers. Many treatment providers described streamlining their intake processes to reduce burden on clients and speed up access to MAT.
- **Assessing and aligning policies with values and goals.** A few treatment grantees had the goal of improving equitable access to services by directing outreach to specific populations. Grantees focused on the unhoused population, and Latine/Hispanic, Native American, and rural communities. Some examples of aligning practices with equity goals are Medford Treatment Center (MTC) updating forms to be gender inclusive, and Willamette Family implementing a DEI initiative at their agency. NWIL updated their equity agreement with community groups, which stated that "in order to use our space, all community support groups must allow any LGBTQ2SIA person to attend any support group that they feel most fits their chosen gender. Failure to comply with this agreement will result in expulsion of that meeting or person from the space."
- **Using data to support decisions and program improvement.** Several treatment grantees collected client demographic data and feedback to improve services. For example, Comagine Health, the Project Nurture implementation team, described developing a "participant feedback tool for sites to utilize to further identify gaps in service, gather participant feedback in the care they receive, and track progress of integration efforts from the participant's perspective."
- **Building & maintaining partnerships.** In addition to partnerships built in response to challenges, as described previously, many treatment grantees worked to increase access to services by partnering with community organizations, e.g., jails, emergency departments (EDs). Grantees also built relationships with local culturally-responsive organizations to develop referral pathways and increase access to treatment services for specific communities. For example, Best Care coordinated with their other locations to improve access for Native American, Latine/Hispanic, and rural communities. Another example is OHSU Harm Reduction & Bridges to Care (HRBR) clinic's partnership with an online MAT prescriber, necessitated by a shortage of X waivered prescribers and, as a MAT bridge clinic, their need to connect clients with long-term MAT services.
- **Assessing and supporting staff buy-in.** A number of grantees said they had to respond to some degree of stigma within their agencies due to misinformation about MAT, harm reduction, and outdated beliefs about what recovery "should" look like. Many shared navigating this issue by providing education, sharing client success stories, and "ongoing program check ins" with staff.

Treatment grantees also reported some ongoing implementation barriers related to the ***organization*** and ***competency*** drivers in terms of planning and staffing challenges.

- **Staffing challenges.** Some grantees struggled to offer competitive wages that were commensurate with staff experience and/or the cost of living. In response, grantees adjusted job duties, offered

sign-on bonuses to attract qualified applicants, and/or utilized current staff or hired part-time staff to fill vacant positions. Fora Health had the goal of hiring bilingual/bicultural staff and made efforts to reach a more diverse applicant pool by advertising within smaller community networks; however, they were unsuccessful in reaching their goal.

- **Data management infrastructure.** Some grantees did not have a data management system that fully supported their services. For example, some grantees providing MAT in behavioral health settings noted that their EHRs did not adequately support tracking and billing for medical services.
- **Additional planning and implementation support.** Several treatment grantees said they needed additional support and TA from expert consultants and/or opportunities to network with SOR2 grantees doing similar work. Some areas of support mentioned were "operationalizing" services; sharing ideas, goals, achievements, and challenges; and discussing "creative uses of funding." One grantee further explained that overlapping grant funding can create confusion for budgets and reporting and requested continued support in this area.

Upstream Prevention & Early Intervention

Upstream prevention/early intervention activities included various educational and strategic planning efforts. Grantees primarily described activities related to ***organization*** drivers such as assessing community needs using data and input from invested community partners, building relationships, and identifying core values and aligning policies and procedures with those values.

- **Key invested community partner input.** Most upstream prevention/early intervention grantees described getting input from community partners, key constituents, those with lived experience, and expert consultants. Grantees convened committees and working groups, distributed surveys and collected data, and compiled educational documents to inform their planning. For the Strategic Planning Initiative (focused on strengthening the SUD care continuum), Lines for Life recruited staff from organizations providing services to those with SUD and community members with lived experience to form a Leadership Team. For the Oregon Conference on Opioids and Other Drugs, Pain, and Addiction Treatment (OPAT), Lines for Life similarly described seeking input from communities disproportionately affected by the opioid

Facilitative Administration Driver: Lines for Life

Lines for Life named various ways they are working to build partnerships with diverse communities. Some examples are that they:

- Noted the significance of "*the trust that has been built with the Tribal Learning Academies that is broadening tribal participation in the planning and participation in the OPAT conference*."
- Described "*intentional efforts to increase organizational equity and community outreach [which has] broadened inclusion of Spanish-speaking health and treatment partners and other communities of color in the planning and participation in OPAT 2021/22*."
- Hired "*a Veteran Military Outreach Liaison who is expanding relationships and collaboration with [Oregon Department of Veterans' Affairs] and other veteran and military serving organizations including the LGBTQ+ communities*."

crisis including communities of color, veterans, and LGBTQ+.

- **Building new partnerships.** Many grantees described building partnerships to support the development of more equitable and inclusive services, recruit and increase access to and participation in trainings, distribute materials, and collaborate on planning. For example, the Oregon Department of Education (ODE) was surprised by the length of time it took to navigate their own internal processes and, in turn, they worked to increase collaboration between their offices to streamline their curriculum development processes.
- **Assessing need and readiness for change.** Grantees reached out to community partners to assess interest and readiness for change, and collected data through surveys and focus groups to understand gaps in services and community needs. For example, to help select rural counties to engage in the Strategic Planning Initiative, Lines for Life reached out to community partners to assess interest and readiness. ODE worked to better understand community needs through a statewide survey, focus groups with teachers, and eliciting help from community partners.
- **Aligning policies with values and goals.** An internal review of current policies and procedures can help identify where confusion or conflicts might arise in response to new policies and procedures. Several grantees described reviewing and updating policies and materials. For example, Lines for Life created a new position, Director of Equity and Inclusion, to support their value for equitable service delivery. As another example, Change Management described making updates to the Oregon Pain Management Commission pain education module *to include* "a new section on health equity in communities of color, people with lower incomes, people who live in rural areas, people who identify as LGBTQ+, and people with disabilities."

Other than COVID-19, grantees doing upstream prevention and early intervention work noted few barriers. However, OHA discontinued the Coordinated Youth Serving Systems project in Year 2. This organization noted challenges with communication and collaboration with partners, pointing to the need for additional implementation support for youth-focused upstream prevention work.

Sustainability Planning

The NIRN framework suggests that sustainability planning, both in terms of financial and programmatic sustainability, is a part of every stage of implementation. *Financial sustainability* pertains to adequate, ongoing funding streams, and *programmatic sustainability* refers to establishing reliable implementation infrastructure.[8] As reflected in the previous section, grantees described in their progress reports extensive efforts to build infrastructure that contributed to their sustainability:

- Much of the infrastructure developed pertained to ***staffing*** for SOR2-funded activities – developing new positions; recruiting and hiring staff; establishing funding streams to offer competitive wages and benefits; creating and providing training for new and existing staff; and developing a system for remote supervision.
- Grantees developed and updated ***policies, processes, and plans*** to align with their SOR2-funded activities (e.g., updated their pain management agreement and safe opioid prescribing policy; established CCO prior authorization; wrote a tele-HCV manual, created new referral pathways, Emergency Overdose Response Plan).

[8] https://nirn.fpg.unc.edu/module-1/implementation-stages/sustainability

- Grantees created ***toolkits, assessments, and tracking systems*** to support their SOR2-funded activities (e.g., Pain Education Toolkit, strategic planning needs assessment, ODE gap assessment, harm reduction supply distribution tracking system, RecoveryLink for tracking PRIME+ client data).
- For ***marketing and outreach***, grantees developed websites, videos, social media campaigns, onboarding materials, flyers, messaging).
- Grantees spent resources developing ***collaborative partnerships*** (some were formal, e.g., providing fiscal management, forming a Minority Recovery Center Community Organization, sponsorships), and doing ***advocacy*** with the state legislature.

The Year 2 mid-year progress report asked grantees to share their plans for sustaining their SOR2-funded activities. The following is a summary of the strategies that grantees described.

- **Achieve financial sustainability through federal, state, and local grants.** Most grantees reported they would turn to federal, state, and local grants to ensure the financial sustainability of their SOR2-funded activities. They would apply for grants, work with foundations and community sponsors, seek out individual donorships, and acquire other miscellaneous funding (e.g., fundraising events). Some grantees had already secured funding. For example, Harmony Academy noted they "secured funding through the Youth Development Division and through Oregon Department of Education funding streams like Student Investment Account and the High School Success fund. We accept private donations of all sizes and expect to have a fundraiser this fall."
- **Promote sustainability by establishing billing infrastructure.** Many grantees noted the need to have infrastructure in place for billing Medicaid and private insurers and hiring/maintaining staff. For example, Mid-Columbia Center for Living said that the partnership with their local CCO is critical to their ability to continue providing MAT services. "Our local CCO (PacificSource) has agreed to fund our MAT program ongoing with a capitated, per member per month funding agreement."

  In addition, grantees discussed building capacity among program staff through training, hiring credentialed staff who can bill for services, relying on hard funded positions to maintain staff, and a volunteer workforce. Best Care hoped to maintain their credentialed staff so they can continue to provide billable services. "[The Registered Nurse] is also trained as a QMHP [Qualified Mental Health Provider] and able to provide billable services as an RN and QMHP. CADC [Certified Alcohol and Drug Counselor] and CRM [Certified Recovery Mentor] are certified and able to provide billable services."
- **Strengthen collaborative partnerships and relationships to leverage resources and efforts.** Many grantees developed partnerships with other organizations to ensure sustainability. NW Instituto Latino "made intentional efforts to partner with other culturally and linguistically specific organizations, as well as established organizations." As another example, Oasis described seeking TA to "receive support with best practices to ensure the sustainability of this important program."
- **Focus on program improvements for long-term sustainability.** Grantees discussed various ways in which they were working toward program sustainability by building evidence of the effectiveness of their program/services, individualizing the program model to local conditions, making improvements to materials and processes, and regularly discussing sustainability in the workplace. As NW ATTC, which provided training and implementation support for CM Treatment noted: "The customization of CM programming at all involved sites reflects an effort from project conception to design clinical services that are tailored to the local needs and resources of these clinical settings, thereby increasing likelihood that the CM programming will be sustainable."

- **Continue as usual.** Some grantees said they planned to continue as usual, especially those that had funding to continue with limited disruption in services. For organizations built upon a self-sufficient model such as Oxford House, a shared pool of funds from monthly dues provided extra support. "These funds are accumulated over time to ensure that when a house needs assistance, they can receive support from the Chapter in the form of a loan that doesn't exceed one year."
- **No plan for sustainability.** Some grantees did not have a sustainability plan or did not see a future for the program in the absence of SOR2 funding. Coquille Tribe shared, "In all honesty in the absence of SOR funding, the program in its current iteration would not be sustained. The lessons learned, systems developed, and prevention activities conducted would have some sustainability based on being institutionalized within the Ko-Kwel Wellness Center but there would be a gap in services provided should there be a gap in funding to support the work."

Grantees responded to questions about recommendations for SAMHSA in supporting sustainability planning on their Year 2 end-of-year progress reports. Aside from additional funding, their top three recommendations were for SAMHSA to provide more opportunities for training (e.g., billing Medicaid for services), TA (e.g., braiding funding sources), and collaboration with other grantees to share achievements, challenges, and lessons learned.

Implementation Key Findings

Overall, implementation successes largely clustered around the NIRN ***organization*** drivers, suggesting that grantees leveraged their organizational strengths to carry out SOR2-funded activities and respond to challenges, especially related to the COVID-19 pandemic. Grantees used collaboration (internal and with external partners), a key strategy embedded in *systems intervention* driver, to build infrastructure supporting their SOR2-funded activities. In terms of the *facilitative administration* driver, they collected and used information to design program improvements. Importantly, many grantees used these strategies to develop culturally-responsive services and/or support access to culturally-specific services, indicating an underlying value for health equity.

Implementation challenges clustered around the NIRN ***competency*** drivers, *selection* and *training.* Grantees had difficulty hiring qualified staff and experienced high turnover (often attributed to the pandemic). Grantees also commonly described ***organization*** driver challenges in aligning internal policies and procedures with new SOR2-funded activities, indicating a possible need for support related to *facilitative administration*. Grantees commonly requested additional TA and opportunities to meet with SOR2 grantees doing similar work to share resources and workshop challenges.

Grantees included fewer examples of activities related to the ***leadership*** driver in their progress reports; however, there were some accounts of leadership supporting organizational change and responding to challenges. For example, in response to staffing shortages, several grantees adjusted credential requirements and adapted training policies to support staff growth within the agency, changes likely due to the guidance and support of their leadership.

Finally, SOR2 funding supported the development of infrastructure that will continue to support financial and programmatic sustainability. Most grantees had plans for sustaining programs through additional grants, partnerships, and program improvements; however, additional support for sustainability planning was a top recommendation made by grantees.

Collaboration: A Pathway and an Outcome

Collaboration is a critical component for carrying out most SOR2-funded activities. It is both a means to increased access to substance use disorder (SUD) services, and itself an outcome that contributes to strengthening Oregon's SUD system. Collaboration can also be a pathway for promoting equity and social justice. Three features of collaboration that promote equity are:

1. The collaboration has the explicit goal of addressing issues of social and economic injustice and structural racism by pursuing equitable power, access to opportunities, community impacts, and outcomes, particularly for communities of color;
2. Collaboration partners have equal power in determining the collaboration's agenda, goals, and resource allocation; and
3. The collaboration engages the communities most affected by the issues.

The SOR2 evaluation conceptualized collaboration as a short-term outcome of funded activities, and sought to answer the following evaluation questions:

1. How did SOR2 funding expand collaboration between agencies/organizations in Oregon's SUD system?
2. What are the effects of collaboration associated with SOR2-funded activities? Did collaborations reflect features that promote equity?

Methods

Developing the Coding Framework

PSU developed a coding framework to help evaluate the information SOR2 grantees shared in their progress reports. To begin this work, PSU reviewed existing literature on types of collaboration, measuring collaboration, levels of integration of organizations, and collaboration effects. Next, PSU combined and adapted models from James Bell Associates (2011) and Bergen and Hawkins (2012) to arrive at a framework that captures three dimensions: (1) types of collaborations, (2) effects of collaborations, and (3) types of collaborators (see Appendix P for codes and definitions). Three PSU team members tested the initial coding scheme by independently coding ten sets of grantee progress reports from the first year of the SOR2 grant and revised the framework to improve clarity.

Data Collection and Analysis

OHA asked grantees to respond to questions about their collaboration efforts as part of progress reporting during three periods: Year 1 mid-year, Year 1 end-of-year, and Year 2 mid-year (see Appendix Q for a list of questions in each reporting period). In total, grantees described collaboration activities for 55 different programs for at least one reporting period (i.e., submitted at least one progress report). PSU evaluation team members independently coded progress reports for each grantee/program and met in pairs to review and reconcile codes. Code counts were tabulated using Excel pivot tables and graphs.

The PSU team examined patterns for all grantees/programs, according to types of SOR2-funded activities (upstream prevention, overdose prevention/harm reduction, treatment, recovery, and workforce development), and for culturally-specific organizations (see Appendix O for a list of grantees).

Results

In this section we summarize the results of our analysis of collaboration efforts that SOR2 grantees described in their progress reports.

Semi-formal and formal collaborations were important in carrying out SOR2-funded activities.

Overall, grantees reported a wide range of collaboration efforts that supported their SOR2-funded activities. They most commonly described ***semi-formal collaboration*** (e.g., voluntarily sharing resources; communication or consultation about shared interests; specific roles for each organization involved in the collaboration; and shared decision making and goals). ***Formal collaboration*** also occurred in all SOR2 grantee clusters, especially for grantees starting new or expanding existing programs (e.g., contractual relationships, MOUs, interdependent activities; contracted/allocated shared resources; ongoing planning; and collective decision making).

The following is an excerpt from a progress report submitted by the Oregon ECHO Network, a workforce development grantee, describing their collaboration with addictions specialists:

> *The collaboration between the Addiction Medicine Section and the Oregon ECHO Network is a strong partnership that allows these programs to reach a diverse group of health professionals across the state. The Addiction Medicine Section experts focus on the curriculum and delivery of the ECHO sessions. The Oregon ECHO Network provides project management, IT support, CME application support, reporting, and other administrative functions to the project.*

Max's Mission, a harm reduction/overdose prevention grantee, described a formal collaboration with a local library system to provide Naloxboxes at their library branches:

> *In May we signed an agreement with Jackson County Library Services to provide a Naloxbox for every branch in Jackson County (15) and be responsible for filling them. They are located on the outside of every branch, clearly visible and with 24 hour access.*

These types of collaboration require more resources than informal collaboration (e.g., joint investments of time and funds, shared power and ownership). In particular, formal collaboration may necessitate substantial time and staff effort (e.g., to execute contracts or memorandums of understanding), which could disproportionately challenge smaller organizations that may not have those resources. This suggests that funding and other supports for semi-formal and formal collaboration would be important for promoting equity among grantees. Semi-formal and formal collaborations are often mutually-beneficial and can lead to more durable system change. They also have the potential to promote equity through shared power in determining goals and resource allocations.

Collaboration was a pathway to expand access to SOR2-funded activities.

Grantees most often described collaboration as a pathway to increase access to services, supports, and resources – for example, to increase referrals to a program to increase an organization's service capacity. Moreover, grantees often reported collaboration with the explicit goals of removing barriers to accessing services (e.g., developing referral pathways between treatment agencies and culturally-

specific community-based organizations). Some examples of how collaboration helped increase access are:

- **Upstream prevention activities**: Worked with partners to conduct community needs assessments, identify gaps in the service array, and develop strategic plans to expand access to SUD services.
- **Harm reduction activities:** Worked with various partners to provide naloxone to the incarcerated, people on probation, and other criminal justice-involved clients. This excerpt from a Save Lives Oregon progress report provides an example of how partnering with culturally-specific organizations can expand equitable access to naloxone:

  > *We are in the later planning stages of adding to our TA team Tribal, LatinX, and Black TA providers to ensure we are reaching all communities in Oregon. We are in process of creating culturally responsive materials and a Spanish campaign name; the website will be in Spanish and English and all materials will be provided in Spanish as well. We have TA providers from both urban and rural settings that bring different perspectives and expertise.*

- **Treatment services**: Collaboration helped expand referral networks into treatment and post-care transitions, and facilitated access to community resources. The excerpt is from a progress report submitted by the OHSU HRBR clinic and how collaboration allowed them to expand their service capacity:

  > *Boulder Care - They have allowed us to transition patients from HRBR to their virtual platform from any location in the state, specifically, in areas where there are no x-waivered providers to continue medications. This has only been possible now that OHP is an accepted insurance.*

- **Recovery services:** Leveraged existing partnerships to increase outreach to people with SUD in community-based, virtual, and person-to-person care settings to connect them with CRMs.
- **Workforce development:** Coordinated efforts with various peer programs to expand outreach for training opportunities to Oregon's peer workforce.

Collaboration was a way for grantees to improve the quality of their SOR2-funded activities.

Grantees also described how collaboration brought resources to their staff, thereby increasing the quality of their services/activities. Some examples include:

- **Prevention activities**: Lines for Life described their collaboration with culturally-specific organizations to improve the quality of the OPAT conference:

  > *Lines for Life has prioritized developing relationships with culturally-specific organizations and particularly organizations serving communities of color to participate in the conference planning process. The conference planning team worked with Lines for Life's Director of Equity and Cultural Engagement to complete an equity review of the conference strategic plan in order to ensure the 2021 conference theme and direction was relevant to and inclusive of communities of color. Lines for Life*

initiated conversations with tribal leadership to include a tribal track at the conference. Lines for Life also developed a call for proposal guidelines that prioritize health equity promotion in underserved and/or marginalized communities as well as lived experience.

- **Harm reduction activities:** Co-created interventions with people with lived experience of substance use to build trust and sustain engagement.
- **Treatment services:** Supported networking and received feedback on culturally appropriate services. Fora Health, an MAT expansion grantee, described how collaborating with Instituto Latino has improved the quality of their services:

  Instituto Latino has welcomed our agency into the Latino Provider's Meeting. This has increased our access to: potential providers, visibility as a developing program, gotten us feedback on cultural appropriateness, resources applicable to patients, and supported our networking.

- **Recovery services:** This excerpt from a progress report submitted by Alano Club is an example of using collaboration to improve equitable access to recovery services and to center communities of color and the LGBT community in their programming.

  In order to serve Black, Brown, AAPI [Asian American & Pacific Islander] and Indigenous people — all populations historically overrepresented in populations experiencing substance misuse and underrepresented in access to available treatment and supports — we have partnered with The Black Resilience Fund, Brown Hope, and to expand our programming to increase the frequency and availability of events, workshops and classes, and create programming that is diverse, and culturally informed, with direct input from those organizations and individuals in their communities. The same can be said of our ongoing partnership with Q Center, an organization that has helped us create and expand programming to better serve the LGBT community. We also expanded Recovery Gym programming to offer more classes to teens in or seeking recovery.

- **Workforce development:** Connected training participants with specialists in the field and built supportive relationships among colleagues.

Many grantees, particularly harm reduction and recovery grantees, described collaborations with culturally-specific organizations to improve the quality of their services. Increasing access to services for the communities most marginalized and underserved is good, as is training for staff to provide culturally-responsive services. To promote equity within the health system, however, it is important to continue funding and supporting capacity building for culturally-specific organizations.

Some collaboration efforts were mutually beneficial, a feature that can promote equity.

Progress reports offered some evidence of mutually-beneficial collaboration efforts, reflecting features of collaboration that can promote equity. As mentioned previously, progress reports generally did not

include information about the extent to which *partners* experienced collaborations as mutually beneficial. Nevertheless, a few grantees provided examples:

- **Harm reduction:** Community collaborations also allowed four harm reduction grantees to provide education, TA, overdose prevention services, and training to community organizations providing harm reduction services.
- **Recovery services:** One grantee described how they were able to connect a collaboration partner's clients with CRMs and other recovery supports. As another example, 4th (4D) Recovery is collaborating with Painted Horse Recovery, a culturally-specific organization serving the Native community, to provide fiscal oversight and capacity building. This excerpt from 4D Recovery's progress report explains:

> *4D accepted the opportunity to help launch a BIPOC-run recovery organization through fiscal management. The organization is Painted Horse Recovery and they provide similar services as 4D, but target the Native community. 4D helped them open a recovery center. 4D also helped the NWIL [Northwest Instituto Latino] open a recovery center and launch harm reduction services.*

4D Recovery and MHACBO are also engaged in mutually beneficial, equity focused collaboration ***(see Grantee Spotlight box on 4th Dimension Recovery and MHACBO)***. These collaborations had the explicit goal of addressing social and economic injustice and structural racism by redistributing access to opportunities and power to BIPOC recovery organizations, and engaging members of the communities.

Spotlight on Collaboration: 4th Dimension Recovery & MHACBO

MHACBO and 4th Dimension Recovery organized an association of recovery community organizations (RCOs), describing it as "a venue for sharing technical assistance, mutual support, dissemination of best practices, and self-advocacy." This innovative model of collaboration intentionally began with culturally-specific recovery organizations developing the association's infrastructure (e.g., mission statement, membership criteria). Rather than expecting culturally-specific organizations to follow the lead of and be managed by white-centered organizations, BIPOC leaders in the RCO Association determine the group's needs, share resources, and direct governance with the goal of increasing the number of culturally-specific organizations providing recovery services.

Collaboration contributed to strengthening Oregon's SUD system.

Grantees did not often identify more distal outcomes, like effects on participants, communities, and systems resulting from collaboration. This could reflect the fact that SOR2-funded activities largely focused on increasing access to and utilization of services. It also reveals an opportunity to support sustainability by encouraging grantees to use collaboration to impact funders, the community, and the SUD systems. Some specific ways in which collaboration for SOR2-funded activities strengthened Oregon's SUD system include the following:

- **Changing the service array.** The Naloxone Clearinghouse and Save Lives Oregon increased the availability of naloxone and supported community-based organizations in training individuals how to prevent overdoses. It also helped develop naloxone distribution routes that reach rural communities, such as Jackson and Josephine Counties, on a regular basis.
- **Improving connectedness within the service array**. Harm reduction/overdose prevention grantees described the most robust collaboration efforts - they worked with the widest range of collaboration partners and achieved the most varied effects through their collaboration efforts. This could have implications for shifting the SUD system toward harm reduction in terms of increased awareness and availability of resources and supplies.
- **Connecting systems**. Some grantees reported collaborations that supported their mutually beneficial connections with other systems. For example, a harm reduction grantee collaborated with local jails to share information and resources while also expanding their services. Another grantee providing treatment services for pregnant and postpartum women collaborated with the state child welfare agency. Another example is harm reduction and recovery grantees providing education, resources, and outreach to schools in their community. As a final example, harm reduction/overdose prevention, treatment, and recovery grantees described collaborating with behavioral and physical health providers to support their SOR2-funded activities. In a system that often silos SUD and behavioral/physical health, it is encouraging to see that SOR funding may have encouraged collaboration in the health system.

Collaboration Key Findings

The following is a summary of key findings pertaining to the impact of SOR2 funding on collaboration, its role in expanding access to SUD resources, and suggestions for supporting future SOR grantees in their collaboration efforts.

Semi-formal and formal collaborations were important in carrying out SOR2-funded activities.

Semi-formal and formal collaboration requires more resources than informal collaboration, which could disproportionately challenge smaller organizations that may not have those resources. Funding and other supports for semi-formal and formal collaboration are important for promoting equity among grantees.

Collaboration was a pathway for grantees to expand access to and improve quality of SOR2-funded activities.

Collaboration emerged as a key mechanism for expanding and improving SOR2-funded activities. Grantees commonly named collaborations with culturally-specific organizations in the pursuit of these goals. It is important to support grantees in considering issues related to who has power to determine the goals of their collaborations, how to equitably allocate resources (e.g., compensating partners for labor), and how to ensure benefits for collaboration partners. It is also important to continue funding and supporting capacity building for culturally-specific organizations.

Some collaboration efforts were mutually-beneficial, a feature that can promote equity.

In a similar vein, future funding should support collaborations with the explicit goal of redistributing access to opportunities and power to BIPOC community leaders and culturally-specific organizations. In this way, collaboration can be used as a tool to address social and economic injustice and structural racism embedded in how resources are allocated.

Collaboration contributed to strengthening Oregon's SUD system.

Collaboration is a way to strengthen connections between organizations contributing to Oregon's SUD system of care, and to find new partnerships with funders, businesses, non-profit organizations, and other community entities to support the sustainability of SOR2-funded activities. Future SOR grantees would benefit from peer learning, networking opportunities, and support connecting to other funding streams.

SOR2 Impact Evaluation

The SOR2 impact evaluation assessed the degree to which SOR2 funding supported progress toward Oregon Health Authority's strategic goals:

- Increase access to SUD recovery support services
- Expand the SUD workforce
- Increase access to harm reduction and overdose prevention
- Increase access to SUD treatment
- Expand SUD prevention and early intervention

The evaluation questions guiding the impact evaluation were:

1. What is the impact of SOR2 funding (across multiple programs, activities, and focal areas) on Oregon's SUD system and its consumers?
2. To what extent has SOR2 funding led to improvements in OHA's strategic goal areas?

Defining Access: Availability and Utilization

PSU organized this work around the SOR2 strategic goals. PSU conceptualized "access" as two distinct but related outcomes: availability and utilization.

- **Availability**: More resources, supplies, learning/training, services, and supports are made available, and individuals/communities/organizations are aware of what was made available.
- **Utilization**: Individuals/communities/organizations are using the resources, supplies, learning/training opportunities, services, and supports, and they experience benefits (e.g., satisfaction, goal achievement, completion of a service).

Distinguishing Impact from Implementation Outputs

It is important to note that these dimensions of access are intentionally active – they require awareness, use, involvement, and derived benefit on the part of people, communities, and organizations. The development of something new (program, curricula, strategic plan, position) without explicit evidence of availability and/or utilization as defined above is summarized in terms of implementation outputs in *Implementation of SOR2-funded Activities*.

Methods

The impact evaluation involved summarizing and assessing the evidence that grantees provided in their bi-annaul progress reports, including supplemental materials. Our process included the following five steps:

Step 1: Developing an evidence rubric. PSU developed a scoring rubric to apply to each piece of evidence (grantee progress reports from three reporting periods: Year 1 mid-year, Year 1 end-of-year, and Year 2 mid-year).[9] First, we reviewed the literature on standards of evidence used to conduct meta-

[9] Due to timing of report deadlines, PSU was unable to include Year 2 end-of-year progress reports in this analysis.

analysis and other macro research methods.[10] PSU initially identified 36 dimensions pertaining to standards of evidence and removed those that would be difficult to evaluate given the type of evidence available from most SOR2 grantees (e.g., statistical precision, theoretical basis, cost efficiency of intervention, legal and ethical justification, quality of assessment instruments, replicability). We then combined similar dimensions (e.g., relevance of outcomes, importance of findings, and applicability) to arrive at 13 key dimensions and grouped them into three descriptive categories: impact, transparency, and equity. Impact (e.g., effect size) and transparency (e.g., discussion of limitations) are common categories for assessing evidence of impact. In alignment with OHA's health equity statement, we also included an equity category with four dimensions so that our assessment of impact prioritized the equitable distribution of resources, procedural justice, and the extent to which disparities among groups most often marginalized were minimized or eliminated.

Second, we created a 4-category coding scheme and wrote descriptions of each category for each of the 13 dimensions. The PSU team arrived at the final rubric (see Appendix R) after several iterations of coding pieces of evidence (grantee progress reports and supplemental materials, as described in *Step 2* and *Step 3* below) and adjusting definitions to ensure applicability to the wide range of SOR2-funded activities.

Step 2: Extracting data from grantee progress reports. PSU read each progress report (Year 1 Mid-year, Year 1 End-of year, and Year 2 Mid-year reports), identified grantees' goals related to availability and utilization, and extracted information describing progress made toward each goal. We considered each grantee's "set" of progress reports over time as one piece of evidence. If grantees included reports or other supporting materials that offered additional information about their SOR2-funded activities, we evaluated them as separate pieces of evidence (see *Step 3* below). Appendix S includes key availability and utilization outcomes extracted from progress reports, along with examples of each.

Step 3: Including supporting materials. Grantees often included supplemental materials with their progress reports. If the document included information related to availability or utilization, and enough context for PSU to be confident that the information pertained to SOR2-funded activities, it was included as evidence for the impact evaluation. PSU also consulted with OHA if it was unclear whether the evidence reflected SOR2-funded activities. For example, a flyer advertising a community event was not included as evidence because there was not enough information to allow for coding. Examples of supplemental materials included as evidence are results from a post-training satisfaction survey, an evaluation report summarizing feedback from conference participants, and a slide deck containing information about fidelity and client outcomes.

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[10] Aday, L.A., Begley, C.E., Lairson, D.R., Slater, C.H., Richard, A.J., & Montoya, I.D. (1999). A framework for assessing the effectiveness, efficiency, and equity of behavioral healthcare. *American Journal of Managed Care*, *5 Spec No: SP25-44*.

Hogan, V., Rowley, D.L., White, S.B., & Faustin, Y. (2018). Dimensionality and the R4P: A health equity framework for research planning and evaluation in African American populations. *Maternal and Child Health Journal*, *22*, 147-153.

Martensson, P., Fors, U., Wallin, S-B., & Zander, U. (2016). Evaluating research: A multidisciplinary approach to assessing research practice and quality. Research Policy, 45, 593-603.

Rychetnik, L., Frommer, M., Hawe, P., & Shiell, A. (2002). Criteria for evaluating evidence on public health interventions. *Journal of Epidemiological Community Health*, *56*, 119-127.

Step 4: Coding evidence using the rubric. During the rubric development phase, three PSU team members separately coded each piece of evidence (grantee progress reports and supplemental materials) for each outcome (availability and utilization) and came to consensus on a final set of codes. Once the rubric was finalized, PSU maintained inter-rater reliability by having two team members separately code each piece of evidence for each outcome and come to agreement on their ratings for each rubric. Final rubric codes were entered in a database for further analysis.

Step 5: Analyzing rubric data. We coded 47 sets of progress reports and 41 supplemental materials for availability outcomes, and 34 sets of progress reports and 30 supplemental materials for utilization outcomes. Codes were entered into a database for analysis. We aggregated codes (sums, frequencies, quartiles) for each piece of evidence (total), and for each of the three conceptual categories: impact, transparency, and equity (sub-totals). We also aggregated and analyzed the codes according to SOR2 strategic goal area (treatment, recovery, etc.), outcome (availability and utilization), and whether the grantee was culturally-specific (yes/no). Last, we analyzed codes for each equity dimension. PSU analyzed the data during a series of group meetings (3-4 team members) in which we examined coding patterns (using pivot tables and graphs), discussed findings with a focus on equity, and conducted further analysis based on questions that arose during each meeting.

SOR2 Impact on Expanding Availability of SUD Resources

Overall, the available evidence suggests that SOR2 funding increased the availability of SUD-related resources, supplies, training opportunities, services, and supports in Oregon. Nearly all grantees made progress toward or accomplished their SOR2 goals during the funding period. The COVID-19 pandemic and a statewide SUD staffing shortage posed significant challenges for grantees in making progress toward their SOR2 goals. The pandemic had a disproportionate impact on communities of color;[11] some culturally-specific organizations faced more challenges implementing SOR2-funded activities because they had to divert their resources to COVID-19 response efforts. For more information about implementation, see *Implementation of SOR2-funded Activities* section of this report.

Next, we summarize key findings related to availability for each of the SOR2 strategic goals, ordered from most to least evidence available (see Appendix O for a list of grantees and their strategic goal areas):

1. recovery support services,
2. SUD workforce development opportunities,
3. harm reduction and overdose prevention services,
4. SUD treatment services, and
5. upstream prevention resources.

Availability of Recovery Support Services

SOR2 funding expanded the availability of recovery services in Oregon, and made progress toward promoting the equitable distribution of resources among priority populations. Based on the progress

[11] Webb Hooper, M., Nápoles, A.M., & Pérez-Stable, E.J. (2020). COVID-19 and racial/ethnic disparities. *JAMA, 323*(24), 2466–2467. doi:10.1001/jama.2020.8598

reports and supplemental materials submitted, there was clear evidence of impact on this strategic goal. Grantees provided evidence of the following impacts on the availability of recovery services:

- **Increased availability of recovery services** including recovery meetings, housing support, recovery events, recovery coaching, peer mentoring, and employment or educational support. Most grantees accomplished this by expanding existing services, but some grantees initiated new services. For example, Northwest Instituto Latino (NWIL) opened Oregon's first Latine recovery center *(see Grantee Spotlight box on NWIL)*.
- **Funding culturally-specific organizations to provide recovery services** that centered communities of color (e.g., African American, Native and Tribal, Latine/Hispanic) and youth, and to support the use of Tribal Best Practices (e.g., Yellowhawk Tribal Health Center launched Pinánayḱukt "Gathering Oneself Together" Program/Sober Transitional House).
- **Funding organizations that had goals to increase access to recovery services for priority populations** (e.g., Latin American, LGBTQIA+, women, rural, people who were unhoused), and/or that worked to provide culturally-responsive recovery services.

Recovery Grantee Spotlight: **Northwest Instituto Latino (NWIL)**

Northwest Instituto Latino (NWIL) opened Oregon's first culturally- and linguistically-specific Latine recovery community organization/drop-in center. They now employ and pay a living wage with full benefits to 11 Latine SUD recovery/ behavioral health professionals.

NWIL provides the following culturally- and linguistically-specific services:

- Peer mentor services to Latine clients
- 13 weekly recovery support groups
- Education on harm reduction practices to community partners and professionals

Significance of SOR2 funding:

- Funding for culturally- and linguistically-specific recovery organization that centers the Latine community.
- Expanded the Latine recovery workforce.
- Promoted equitable access to recovery services for the Latine community.
- Provided for capacity-building partnership between NWIL and a mainstream recovery organization, 4th Dimension Recovery (also a SOR2 grantee).

- **Increased distribution of harm reduction and overdose prevention supplies** through recovery programs (e.g., naloxone kits, syringes, naloxone training). SOR2 helped strengthen the connection between recovery and harm reduction/overdose prevention in part due to their membership in Save Lives Oregon.
- **Efforts to expand outreach and remove barriers** to accessing recovery services (e.g., collaborating with organizations to increase referrals for youth, providing transportation).

Availability of SUD Workforce Development Opportunities

Several SOR2 grantees were funded to provide workforce development opportunities (e.g., training to meet credentialing requirements). To conduct SOR2-funded activities, many more grantees offered

provided training to increase knowledge and skills of their existing workforce. Grantees provided evidence of the following impacts on Oregon's SUD workforce:

- **Increased training opportunities** offered to individuals already in the SUD workforce, as well as those working toward a new career. SOR2 funded MHACBO to provide the Core Adult Addictions Peer Support training program, for example, which attracted participants not currently working in the SUD field. This type of opportunity could help build a pipeline for expanding the peer SUD workforce.
- **Increased availability of training opportunities for priority populations** in rural/frontier areas, individuals with Spanish as their preferred language, and the peer workforce. For example, the Oregon ECHO Network is an innovative tele-mentoring education model for healthcare professionals in Oregon *(see Grantee Spotlight box on Oregon ECHO)*.
- **Reduced financial barriers** to certification by subsidizing the cost of CRM and CADC registration, and reduced barriers to accessing training opportunities by offering them online using virtual meeting platforms.

Workforce Grantee Spotlight: Extension for Community Healthcare Outcomes (ECHO)

The Oregon ECHO Network (OEN), hosted at Oregon Rural Practice-based Research Network. partners with OHSU Addiction Medicine Section to deliver high quality, addiction medicine and chronic pain tele-mentoring programs at no cost to health professionals across the state of Oregon.

ECHO sessions include brief didactic presentations coupled with time for health professionals to present challenges they are experiencing treating pain and SUD in their clinics. The multidisciplinary team of experts and ECHO participants provide feedback and share their experiences. ECHO sessions aim to share perspectives of patients experiencing pain.

Significance of SOR2 funding:

OEN offered training on various topics to hundreds of participants during the SOR2 funding period. These programs fill an important gap for the state in terms of connecting practicing clinicians and health professionals with addiction medicine experts, thereby supporting clinicians to diagnose and treat more patients in their own communities.

Although there was a good deal of evidence suggesting that workforce development grantees expanded access to skill development and certification opportunities, there was less evidence available to assess the degree to which access was equitable. It is noteworthy that none of the workforce development grantees were housed in culturally-specific organizations. Moreover, the evidence was not clear regarding the degree to which training materials, curricula, and approaches were culturally-informed or reviewed through an equity lens. Some grantees described translating materials and offering training courses in Spanish; however, Vietnamese, Chinese, Russian, and Korean are also languages commonly spoken in Oregon.[12]

[12] https://www.oregon.gov/languages/Pages/most-common-state-language.aspx

Many grantees emphasized their efforts to diversify the SUD workforce to better meet the needs of communities most often marginalized and underserved. A diverse workforce that is representative of those receiving services is important for ensuring health equity (Santiago & Miranda, 2014).[13]

- **Grantees that employed targeted recruitment strategies** (primarily Latine/Hispanic providers) and worked to remove financial, language, geographic, and other barriers, appeared to have some success in promoting equitable access; however, it was difficult to assess the full range of efforts and their impact on the SUD workforce.
- **Increasing compensation and workplace benefits** helped attract and retain staff. For example, one grantee acknowledged their success in hiring Latine certified peers: "*by leading the market in base pay, providing full medical benefits and providing culturally and linguistically specific supervision, on-boarding and training.*"
- **Collaborating and partnering with culturally-specific organizations** or consultants to improve recruitment and hiring efforts.

Availability of Harm Reduction and Overdose Prevention Services

SOR2 funding expanded the availability of harm reduction and overdose prevention supplies, training, and supports in Oregon. Many grantees noted the urgency of their work increased substantially when fentanyl entered the drug supply. Based on the progress reports and supplemental materials submitted, there was a good deal of evidence suggesting the impact of SOR2 funding on this strategic goal.

- The **development and expansion of Save Lives Oregon**, a resource hub to provide naloxone and other life-saving supplies to organizations and tribal communities, had a marked impact on the SUD system in Oregon ***(see Grantee Spotlight box on Save Lives Oregon).*** For example, more than 47,000 naloxone kits were purchased using SOR2 funding (see the RMC Research Evaluation Report in Appendix B for more information). By braiding other state and federal funding, SLO was able to distribute 192,000 doses of naloxone and other harm reduction supplies during the SOR2 funding period.
- **SOR2 funded several recovery organizations to provide TA** to organizations in their communities to increase awareness and utilization of the Harm Reduction Supply Clearinghouse. This strengthened the recovery community's connection to harm reduction, an overall impact on Oregon's SUD system.
- Most grantees focused on harm reduction and overdose prevention described **extensive efforts to increase outreach** to their communities, with explicit focus on communities most often underserved and disinvested (e.g., people who were unhoused, incarcerated, LGBTQIA+, Latine/Hispanic, youth, rural).

[13] Santiago, C. D., & Miranda, J. (2014). Progress in improving mental health services for racial-ethnic minority groups: A ten-year perspective. *Psychiatric Services*, *65*(2), 180-185.

- **Grantees used innovative approaches to reduce barriers** to accessing naloxone kits, syringe services, and other harm reduction services and supplies. Examples include partnering with libraries, schools, food banks, laundromats, and other community settings where people who use drugs may frequent; distributing and supplying NaloxBoxes; and mobile and recurring fixed site harm reduction outreach.
- **SOR2 funds also paid for grantees to train community members** and organizations to increase awareness, build skills to use naloxone, and reduce stigma. Some have developed a train-the-trainer approach to expand the impact of their training efforts.
- As part of their harm reduction work, grantees **offered infectious disease screening**, testing referrals, and rapid testing (e.g., Hepatitis C, HIV) along with their syringe services.

Harm Reduction Grantee Spotlight: Save Lives Oregon

Save Lives Oregon (SLO) is a community of organizations working to reduce drug-related harm, support the agency of people who use drugs and end the stigma associated with drug use. SLO is a resource hub that provides life-saving supplies such as naloxone to organizations and tribal communities on the front lines of harm reduction.
The SLO Initiative has two goals:

1. Provide life-saving harm reduction supplies at no cost to partner organizations that qualify.
2. Expand harm reduction services in Oregon.

Significance of SOR2 funding:

Save Lives Oregon expanded with the formation of a Partner Leadership Team that includes harm reduction leaders from Black and Indigenous communities, Spanish speaking communities and other communities of color. Knowing that culture shapes how communities view harm reduction, SLO endeavored to build a team that could best support diverse organizations to engage in the work. Over 120 organizations that serve people who use drugs have accounts set up with the Clearinghouse.

Availability of SUD Treatment Services

SOR2 funding also had an impact on expanding the availability of SUD treatment. Most of the treatment grantees were involved in the MAT expansion, but other grantees provided SUD treatment using the Nurture Oregon, CM, an innovative digital/virtual approach to treatment (Engagement and Outcomes Solutions), and culturally-specific models (e.g., Great Circle Recovery is the first Tribal operated opioid treatment program [OTP] in Oregon which prioritizes treatment to members of the Grand Ronde Tribal community).

Treatment grantees provided evidence of the following outcomes related to availability:

- **Expanding the availability of treatment services**, **focusing on priority populations** including rural and Latine/Hispanic communities, people who are pregnant or postpartum diagnosed with OUD, and people who are incarcerated or on parole. Importantly, grantees focused on providing rapid (same- or next-day), low barrier access to MAT services, an approach to treatment linked

to appointment attendance[14] and improved retention rates, especially for Latine/Hispanic clients.[15]

- **Some grantees had specific equity goals around expanding access** to the Latine/Hispanic community. For example, Fora Health wanted to increase equitable access to SUD treatment by creating a MAT program dedicated to comprehensive, culturally-responsive SUD care for Latine patients, and other residents of northwestern Oregon ***(see Grantee Spotlight box on Fora Health)***.
- **Other grantees implemented CM,** an evidence-based treatment for stimulant use disorder. During the SOR2 funding period, three clinics have had staff trained to implement the CM model with fidelity and are now providing services.
- **Peers (e.g., CRMs) helped strengthen the connection between treatment and the recovery community**. Indeed, research suggests that peers can help eliminate barriers that prevent people from transitioning from one stage of the care continuum to the next.[16]
- Some MAT expansion grantees described how their SOR2-funded work **strengthened the continuum of care** by improving referral pathways and collaboration between SUD

Treatment Grantee Spotlight: Fora Health

Fora Health provides behavioral health services and expanded to include outpatient medication assisted treatment (MAT) focused on the Latine/Hispanic community. As a bridge clinic, they provide short-term MAT services, inducting buprenorphine then focusing on connecting clients to a long-term prescriber.

Significance of SOR2 funding:

Fora Health focused on creating culturally responsive, trauma-informed, and harm-reducing care, with the understanding that bicultural/ bilingual staff are necessary to serve their community. They are making organizational culture shifts to attract bicultural/bilingual staff and working to make services more accessible for patients by:

- Collaborating with CareOregon (Medicaid billing) to create sustainable pathways to provide MAT in a behavioral health organization.
- Using non-clinical support, such as peer mentors who reduce barriers for our patients.
- Eliminating the expectation that patients will engage in counseling or other treatment as a prerequisite to receiving medications.

[14] Roy, P.J., Choi, S., Bernstein, E., & Walley, A.Y. (2020). Appointment wait times and arrival for patients at a low-barrier access addiction clinic. *Journal of Substance Abuse Treatment, 114*. https://doi.org/10.1016/j.jsat.2020.108011

[15] Lee, C.S., Rosales, R. Stein, M.D., Nicholls, M., O'Conner, B.M., Loukas Ryan, V., & Davis, E.A. (2019). Brief report: Low-barrier Buprenorphine initiation predict treatment retention among Latinx and non-Latinx primary care patients. *The American Journal on Addictions, 28*, 409-412.

[16] Stanojlovic, M., & Davidson, L. (2021). Targeting the barriers in the substance use disorder continuum of care with peer recovery support. S*ubstance Abuse: Research and Treatment*, 15, 1-10.

treatment, MAT, behavioral health, and harm reduction services (see *Collaboration: A Pathway and an Outcome* for more details).

- Some grantees also provided evidence of their efforts to **increase clients' access to infectious disease screening**, testing, vaccination, and treatment; however, they described several challenges in doing this work. As part of the SOR2 evaluation, PSU completed a special project designed to better understand infectious disease protocols for each of the MAT grantees (see Appendix N for a summary of findings). Grantees pointed to barriers related to billing, data management and referrals, and staffing.

Availability of Upstream Prevention Resources

Upstream prevention activities were wide-ranging, making it difficult to describe patterns of outcomes for these grantees. We divided grantee activities into three broad categories: youth prevention, training, and strategic planning.

- **Youth prevention.** ODE developed a statewide health curriculum for students focused on alcohol, tobacco, and other drug use prevention. Several tribal grantees engaged in youth prevention work using culturally-specific models. For example, the Confederated Tribes of the Coos, Lower Umpqua, and Siuslaw Indians (CTCLUSI) use the Cultural Is Prevention model and are working to bring back The Healing of the Canoe program that was interrupted during the COVID-19 pandemic ***(see Grantee Spotlight box for more information about CTCLUSI)***.

  The Rede Group received SOR2 funding in Year 1 to support OHA in understanding the youth substance use prevention, treatment, and recovery landscape in Oregon, and the opportunities and gaps in OHA's capacity to address these social determinants that produce health inequities. Limited progress was made in this area (resulting in the termination of this contract during the first year of SOR2 funding), highlighting an area in need of future investments.

Prevention Grantee Spotlight: Confederated Tribes of the Coos, Lower Umpqua, and Siuslaw Indians (CTCLUSI)

CTCLUSI is using a culturally-specific curriculum known as Healing of the Canoe (HOC) to teach tribal youth about the journey of life and how to navigate its obstacles. HOC builds knowledge of cultural practices and keeps youth from engaging in harmful activities such as alcohol and drug use.

Significance of SOR2 funding:

- Funding for tribal health organization that centers the Native community.
- Promoted equitable access to youth prevention services for the Native community.
- Encourages youth to take leadership roles in their own tribal community and restoring the wisdom of elders to their community.

- **Training.** Funded training opportunities related to pain management included conferences and online training focused on prescribing practices for pain management. Grantees noted several efforts related to expanding access to these trainings including:
  - *Oregon Conference on Opioids + Other Drugs, Pain + Addiction Treatment (OPAT) Conference*: Provided scholarships to peers and individuals with lived experience and to

tribal members; did an equity review of the conference strategic plan to ensure the 2021 conference theme and direction was relevant to and inclusive of communities of color; discussed with the OHA Tribal Affairs Director the possibility of doing a tribal conference track; and broadened inclusion of Spanish-speaking health and treatment providers and other communities of color in planning.

- *Tribal Opioid Training Academy*: Held the first virtual academy, culturally-specific training to support Tribal Based Practices.
- *Changing the Conversation about Pain*: Provided an online professional development course now required for all clinicians in Oregon; developed online Pain Education Toolkits for various audiences (e.g., patients, clinicians, general public, peer support workers); developed resources for peer workers co-created by people with lived experience.

- **Strategic planning.** The goal of the Strategic Planning Initiative was to create integrated models for the continuum of addiction treatment and recovery and public health efforts in rural counties. Local collaborations increased their readiness and capacity for implementing strategic plans at the county and local level.

SOR2 Impact on the Utilization of SUD Resources

Compared to expanding the availability of SUD resources, there was less evidence available in grantee progress reports and supplemental materials to evaluate the impact of SOR2 funding on the *utilization* of SUD resources. We defined *utilization* as individuals, communities, and/or organizations ***using*** the resources, supplies, learning/training opportunities, services, and supports, and ***experiencing benefits*** (e.g., satisfaction, goal achievement, completion of a service) as a result. This "higher bar" for evidence of impact is challenging to achieve because it requires data collection, tracking systems, and evaluation, activities that go beyond most organizations' capacity and because of time needed to show evidence of utilization. Regardless, many grantees provided evidence of SOR2-funded activities' impact on utilization.

Grantees in all SOR2 strategic goal areas provided evidence of impact on utilization of their funded activities. On the balance, grantees funded to provide recovery support, SUD treatment, and workforce development opportunities were able to offer more evidence pertaining to utilization. It was likely more challenging to demonstrate the utilization of upstream prevention and harm reduction activities because it is difficult and complicated to track the direct impact of work that broadly targets communities and regions compared to, for example, a specific group of clients receiving treatment or individuals participating in a training program. Several grantees had evaluation support (e.g., Comagine, Lines for Life, OHSU) and were able to provide more evidence of their impact. This points to the importance of data collection, reporting, and evaluation support for grantees as they work to monitor their progress toward goals, ensure equitable access and outcomes for clients, and assess the quality of their services.

Utilization of Recovery Support Services

Based on the progress reports and supplemental materials submitted, there was evidence that individuals used and benefited from SOR2-funded recovery support services. There was also some

evidence that the funded recovery support services promoted health equity in Oregon. The following is a summary of how SOR2 funds supported the utilization of recovery support services:

- Indicators of the use of recovery services included the number of people attending recovery meetings, receiving recovery mentoring, or living in recovery housing; contact hours with mentors; and length of engagements with mentors. **SOR2 funding supported over 7,800 clients in utilizing recovery services** (see Appendix A for counts of clients who received services).
- **Many of the recovery grantees were culturally-specific organizations** serving Native, Black, and Latine/Hispanic populations. Other recovery grantees described intentional strategies to provide culturally-responsive services and/or shared disaggregated client data to assess whether the people using their services reflected their broader community.
- **Several grantees collected data from clients** pertaining to their satisfaction with recovery services and recovery capital. Based on the available evidence, clients were generally satisfied with their recovery mentors and improved their recovery capital (e.g., improved their housing and/or employment, gained access to health care).
- Grantees providing recovery support and treatment services collected GRPA data at client intake and again six months after intake. Results suggest that **clients had reduced alcohol and drug use, and increased quality of life in terms of housing, employment, finances, avoiding involvement with corrections, and various indicators of health** (for more information see Appendix B for the RMC Research Evaluation Report).
- Recovery grantees provided some evidence of the **utilization of harm reduction training and supplies**. For example, Oxford House trained recovery housing residents on the use of naloxone, increasing their ability to recognize an overdose.
- One recovery grantee, Harmony Academy, provided evidence of **utilization (use of services and positive outcomes) for youth** involved in their Recovery High School ***(see Grantee Spotlight box for Harmony Academy for more information)***.

Recovery Grantee Spotlight: Harmony Academy

Harmony Academy Recovery High School provides low barrier access to recovery supports embedded in a public school program. Special education services increase access to free and appropriate public education for youth ages 14-21 with co-occurring disorders and disabilities.

Significance of SOR2 funding:

- Outreach to over 100 youth, and enrolled 49 in the program.
- Supported youth development activities (public speaking, advocacy, training).
- Students graduated from the program, acquired high school credits, accessed higher education, and secured employment.
- Fully launched the first year of the adolescent recovery capital scales instrument that will provide data on efficacy, lead to program improvement, and help advocate for services.

Expanding the SUD Workforce

Grantees funded to provide workforce development opportunities provided evidence of participation, and in some cases, benefits accrued from participation. Another way in which SOR2 funding expanded the SUD workforce was through hiring, training new and existing staff, and promotion (see *Implementation of SOR2-funded Activities* section for more details related to grantees' hiring experiences). The following is a summary of the ways in which SOR2 funding helped expand the SUD workforce:

- Workforce development grantees provided trainings to move participants toward fulfilling requirements for credentialing (e.g., CADC, CRM). Some participants even obtained their credentials within the SOR2 funding period ***(see Grantee Spotlight box for more information on the MHACBO Core Peer Training)***. As part of the SOR2 evaluation, PSU conducted a special project to learn about how two workforce grantees impacted training participants' career trajectories (see Appendix H, Appendix I, and Appendix J for summary reports).
- Hiring new staff was most common among grantees providing harm reduction/overdose prevention, treatment, and/or recovery services, suggesting that **SOR2-funded hiring focused on increasing organizations' capacity to provide direct services**.
- The SOR2 Year 1 end-of-year progress report (reporting period: September 30, 2020 to September 29, 2021) asked grantees to provide counts of new staff hired for SOR2-funded activities. **Most staff newly hired for SOR2-funded activities were direct service providers** (e.g., nurse, counselor, doctor, peer) and the remaining were other program staff (e.g., coordinators, supervisors, trainers, administrative staff).
- Grantees acknowledged that adequate staffing, both in terms of number and qualifications, helped their organizations better meet client and community needs. This included both growing the capacity of their existing services, expanding services to new populations (e.g., outreach to people who were unhoused; prenatal services), and integrating services (e.g., incorporating staff with SUD knowledge into physical health settings and integrating mental health and SUD services).

Workforce Grantee Spotlight: MHACBO Core Peer Training

The Mental Health and Addiction Certification Board of Oregon (MHACBO) provided the OHA-approved 40-hour Core Adult Addictions Peer Support training program, which fulfills the education requirement for Certified Recovery Mentors (CRM) and Peer Support Specialists (PSS).

Significance of SOR2 funding:

- The training was offered in English and Spanish, and 169 people participated.
- Reduced financial barriers by offering free training and registration for MHACBO certification.
- 75% of participants earned a certification within 9 months of completing the training, and for most this was their first certification.
- Trainings reached the rural/frontier workforce, people who had not pursued secondary education, and Spanish-speaking Oregonians. Participants were more racially diverse than Oregon's population.

Many grantees described intentional efforts to increase their peer workforce (e.g., staff with lived experience with SUD). One grantee noted that hiring staff with lived experience is "*extremely important in understanding addiction, treatment, and local resources,*" and another grantee said that peers provide "*organizational wisdom and guidance*." Based on the SOR2 Year 1 end-of-year progress report, nearly half of the peers carrying out SOR2-funded activities were newly hired, suggesting an expansion of the peer SUD workforce.

Last, SOR2 funding allowed grantees to develop the existing SUD workforce. Some examples include:

- The Year 1 end-of-year progress report asked grantees to provide counts of staff who were working on or completed certifications necessary for carrying out SOR2-funded activities. Most of these staff were peers, counselors, and doctors.
- The Cow Creek Tribe partnered with the Opioid Response Network (ORN) to advance their MAT program and offer staff training to 35 clinic employees. With assistance from ORN consultants, Cow Creek behavioral health staff presented the training, "Opioid Overview: Hope for our Future." This effort centered the tribe, built infrastructure (i.e., a culturally-informed training), increased staff knowledge, and improved their MAT program.
- Grantees provided training for staff outside of their own organizations. For example, prevention and harm reduction grantees reported on the wider impacts of the training and TA they provided to the SUD workforce as well as community partners. One grantee stated, "*By training these community partners we are improving the understanding of harm reduction and service delivery for people who use drugs in our community*."

Harm Reduction Grantee Spotlight: PRIME+

The PRIME+ Peer Program connects certified Peer Recovery Support Specialists and Certified Recovery Mentors with people who are at risk of or receiving treatment for overdose, infection, or other health issues related to substance use using a harm reduction approach.

Significance of SOR2 funding:

- Supported the growth of PRIME+ programs such that they are now in 24 of Oregon's 36 counties.
- Created referral pathways to PRIME+ from hospitals/EDs, health clinics, syringe service programs, the criminal justice system, recovery residences, and other sources.
- Extensive community outreach to encampments, laundromats, bottle drops, and other places frequented by people who use drugs. Distribution of harm reduction supplies.
- Evidence of beneficial outcomes for participants related to health, crisis support, reduced substance use, reduced use of the emergency room for mental health or substance use, housing, employment, and infectious disease testing.

Utilization of Harm Reduction and Overdose Prevention Services

Providing evidence of utilization was more challenging for grantees providing harm reduction and overdose prevention services. Many organizations did not have the capacity to track, for example, the

number of people using the naloxone they distribute. However, harm reduction and overdose prevention grantees reported the following utilization outcomes:

- Several grantees collectively reported thousands of overdose reversals in their catchment areas during the SOR2 funding period, and millions of syringes exchanged. SOR2-funded naloxone grantees reported more than 1,800 overdose reversals during the SOR2 funding period (see Appendix B for the RMC Research Evaluation Report for more details). Using other state and federal funds, organizations involved with SLO reported more than 2,000 overdose reversals.
- HIV Alliance supported hundreds of people getting tested for hepatitis C and HIV.
- SOR2 funded the PRIME+ Peer Program in 12 counties. With Comagine providing implementation and evaluation support, along with a SOR2-funded web-based peer services database called RecoveryLink, there was strong evidence of the impact of PRIME+ on clients' utilization of these harm reduction-focused services ***(see Grantee Spotlight box for more information about PRIME+)***.

Utilization of SUD Treatment Services

SOR2 funding also supported the utilization of SUD treatment services, including MAT, CM, Nurture Oregon, culturally-specific models and Tribal Best Practices. More than 4,900 clients accessed OUD treatment and nearly 900 accessed stimulant use disorder treatment during the SOR2 funding period according to grantees' progress reports.

Although treatment grantees provided counts of clients served, there was relatively less evidence available to assess utilization. Grantees that had evaluation partnerships were more likely to collect and report data related to clients' use and benefit from their services. For example, a large share of Nurture Oregon clients engaged in peer services, received prenatal care, and participated in well-child checks with their infants. NW ATTC supported the implementation of CM at three of the Oregon Recovery and Treatment Center's locations. They provided evidence of initial clinical effectiveness at the MTC ***(see Grantee Spotlight box for NW ATTC and MTC for more information)***.

Treatment Grantee Spotlight: Medford Treatment Center & NW ATTC

NW ATTC provided CM training and technical assistance to all clinical staff identified by the MTC. NW ATTC worked with MTC to design customized CM programming. Trained staff were evaluated to ensure fidelity, and NW ATTC supported MTC in developing readiness for implementation.

Significance of SOR2 funding:

- Using their customized CM protocol, NW ATTC evaluated clinical effectiveness and found an increase in stimulant-free urine screens and increased treatment retention compared to a baseline period preceding CM.
- Developed a CM resource library for continuing supervision of CM service delivery and onboarding future staff, which contributes to sustainability.
- Two more ORTC sites (Springfield Treatment Center and Grants Pass Treatment Center) started implementing CM.

As reported in the Utilization of Recovery Support Services section, recovery support and treatment grantees collected GRPA data at client intake and again six months after intake. Results suggest that clients had reduced alcohol and drug use, and increased quality of life in terms of housing, employment, finances, avoiding involvement with corrections, and various indicators of health (see Appendix B for the RMC Research Evaluation Report with a more detailed analysis of GPRA data).

Treatment grantees had utilization goals related to infectious disease assessments, vaccinations, and referrals for treatment, and ongoing monitoring and support; however, most did not provide evidence of the number of clients who received these types of services (see Appendix N for results from the Infectious Diseases Protocol special project describing the challenges that MAT grantees faced in expanding their infectious disease services).

Utilization of Upstream Prevention Efforts

Like the harm reduction and overdose prevention grantees, the nature of upstream prevention work makes it challenging to build evidence for utilization. However, within each of the three broad categories of upstream prevention activities, grantees provided the following evidence of utilization:

- **Youth prevention.** The Oregon Department of Education started to pilot the lesson plans for the health curriculum focused on opioid prevention and alcohol, tobacco, and other drug use prevention.
- **Training.** The grantees providing prevention training around prescribing practices and pain management had evaluation partners and were able to provide evidence of utilization. For example, Lines for Life supported the development of the Tribal Opioid Training Academy, which 85 people regularly attended and most participants reported being satisfied with the training content. Change Management reported that over 6,000 clinicians participated in the Changing the Conversation about Pain online education course, over a million page views of their online pain education toolkits, and high participant satisfaction ratings related to course content and design, and commitment to changing their practices.
- **Strategic planning.** The Strategic Planning Initiative involved conducting community needs assessments and developing strategic plans in four rural counties. Lines for Life engaged with a

Prevention Grantee Spotlight: Lines for Life Strategic Planning Initiative

The Strategic Planning Initiative (SPI) provided 8 months of free technical assistance to four Oregon counties with established workgroups comprised of community leaders from across primary care, substance use treatment, public health, law enforcement, harm reduction services, behavioral health, and community service sectors.

Counties participated in an assessment of direct service provider needs to provide deeper insight into COVID-19 impacts on SUD prevention, treatment and recovery services, including identifying areas for community capacity building and care coordination. Next, they participated in a strategic planning process to develop goals and actions that address identified needs from the SPI needs assessment, and align with other county plans and initiatives.

As a last step, counties identified goals and actions, along with potential future funding sources, to continue implementing their plans over the next year.

variety of community stakeholders and community leadership to investigate substance use disorder and overdose trends, identify local resources and services, identify community challenges and gaps, and strategize community-level solutions ***(see Grantee Spotlight box for Lines for Life for more information).***

Key Findings from SOR2 Impact Evaluation

The purpose of the SOR2 impact evaluation was to assess the degree to which SOR2 funding supported improvements in OHA's strategic goals of expanding access to (1) SUD recovery support services, (2) SUD treatment services, (3) harm reduction and overdose prevention services, (4) prevention activities, and (5) workforce development opportunities. Grantees submitted bi-annual progress reports and other supporting materials as evidence of progress made toward SOR2-funded goals.

Evidence suggests that SOR2 funding increased the availability of SUD-related resources, supplies, training opportunities, and services in Oregon. Despite challenges created by the COVID-19 pandemic and a statewide SUD workforce shortage, SOR2 grantees made progress toward or accomplished their SOR2 goals during the funding period. Compared to expanding the availability of SUD resources, there was less evidence available to evaluate the impact of SOR2 funding on the utilization of SUD resources. Demonstrating the use of and benefits from SUD-related resources is challenging because it requires data collection, tracking systems, and evaluation – activities that exceed most organizations' capacity. Showing impact on utilization also likely requires more time than was available to grantees in a two-year funding period. Specific key findings include:

SOR2 funding substantially influenced SUD recovery support services in Oregon.

Twenty grantees reported that over 7,800 clients received recovery services during the SOR2 funding period. They reported an increase in the availability of recovery meetings, housing support, recovery events, recovery coaching, peer mentoring, and employment or educational support. Most grantees accomplished this by expanding existing services, but SOR2 also provided funding for new services. SOR2 funding also helped strengthen connections between recovery and harm reduction/overdose prevention.

Grantees also promoted equitable access to recovery services. The Northwest Instituto Latino (NWIL), for example, opened Oregon's first recovery center for the Latine/Hispanic community. Moreover, several culturally-specific organizations were funded, increasing the availability of recovery services that center specific communities (e.g., African American, Native, Tribal, Latine/Hispanic) and youth. Several agencies were working toward increasing access to recovery services for priority populations (e.g., Latin American, LGBTQIA+, women, rural, people who were unhoused) and providing culturally-responsive services.

Several recovery grantees provided evidence that clients were satisfied with their recovery services and increased their recovery capital (e.g., improved their housing). An analysis of GRPA data suggested that recovery clients experienced reduced alcohol and drug use and increased quality of life (e.g., housing, employment, finances, health) within six months of intake.

SOR2 funding contributed to expanding Oregon's SUD workforce by creating new professional development and hiring opportunities.

Workforce development grantees offered training that met credentialing requirements, and others provided training to increase knowledge and skills in the existing workforce. There was also evidence of participation, and in some cases, benefits accrued from participation (i.e., participants were satisfied with training experience, moved toward fulfilling requirements for credentialing and/or obtained credentials).

Another way in which SOR2 funding expanded the SUD workforce was through hiring, training new and existing staff, and promotion. Although many grantees described challenges with recruiting and retaining qualified staff, they also reported hiring new staff during the SOR2 funding period. This was particularly true for grantees providing harm reduction/overdose prevention, treatment, and/or recovery services, a pattern that suggests an increased capacity to provide direct services. There was also evidence that SOR2 funding expanded the peer workforce in Oregon. When grantees had difficulty hiring new staff, many offered training and credentialing opportunities to upskill existing staff.

In terms of promoting equity, SOR2 funding increased the availability of training opportunities for priority populations in rural/frontier areas, individuals with Spanish as their preferred language, and the peer workforce. It is noteworthy that none of the workforce development grantees were housed in culturally-specific organizations. Moreover, the evidence was not clear regarding the degree to which training materials, curricula, and approaches were culturally-informed or reviewed with an equity lens.

Many grantees emphasized their efforts to diversify the SUD workforce to better meet the needs of groups often marginalized and/or underserved. Grantees employed multiple strategies including identifying priority provider populations for targeted recruitment, increasing compensation and benefits, offering culturally- and linguistically-specific training and supervision, collaborating with culturally specific organizations or consultants to improve recruitment and hiring efforts, and doing an equity review of their hiring rubrics.

SOR2 funding expanded the availability of harm reduction and overdose prevention supplies, training, and supports in Oregon.

The development and expansion of Save Lives Oregon, a resource hub to provide naloxone and other life-saving supplies to organizations and tribal communities, had a substantial impact on the SUD system in Oregon. Harm reduction and overdose prevention grantees described extensive and innovative efforts to increase outreach to their communities, with explicit focus on communities most often underserved and disinvested (e.g., people who were unhoused, incarcerated, LGBTQIA+, Latine/Hispanic, youth, rural). Training and TA contributed to increasing awareness of the Naloxone Clearinghouse and reducing stigma associated with harm reduction.

Providing evidence of utilization was more challenging for grantees providing harm reduction and overdose prevention services, as many organizations do not have the capacity to track the actual use of supplies. However, several grantees collectively reported thousands of overdose reversals in their catchment areas during the SOR2 funding period, millions of syringes exchanged, and hundreds of people tested for infectious diseases. There was also strong evidence of the impact of PRIME+ on clients' utilization of these harm reduction-focused services.

SOR2 funding had an impact on expanding the availability of SUD treatment.

SOR2 funding supported the expansion of MAT and CM services in three more rural counties. Most treatment grantees were involved in the MAT expansion, but other grantees provided SUD treatment using the Nurture Oregon, CM, culturally-specific models, and an innovative digital/virtual treatment practice. According to grantee counts, more than 4,900 clients accessed OUD treatment and nearly 900 accessed stimulant use disorder treatment.

There was some evidence available to evaluate utilization, or clients' use of and benefit from treatment services. Grantees with evaluation partners provided reports describing positive impacts for clients related to engagement in peer services, prenatal care and well-child checks, and treatment retention. GRPA data suggest that clients had reduced alcohol and drug use, increased quality of life, and improved overall health. Some grantees also provided evidence that clients were getting tested and treated for infectious disease despite the challenges they faced in doing so.

Several SOR2 grantees had goals for expanding access to SUD treatment services for priority populations, particularly rural and Latine/Hispanic communities. However, there was little evidence available to evaluate equitable service delivery and outcomes for different groups, suggesting an area in need of further evaluation.

There was also evidence that SOR2 funding contributed to strengthening the care continuum between SUD treatment, MAT, behavioral health, harm reduction services, and recovery. Notably, the peer workforce bridged these services alongside clients, as did work developing referral pathways and formal or semi-formal collaboration efforts to integrate services.

SOR2 funding supported the development of curricula, training opportunities, and strategic plans for preventing SUD.

SOR2-funded upstream prevention activities included youth prevention, training, and strategic planning. The youth-focused work focused on developing and delivering curricula, some culturally-specific, to prevent youth substance use. There was less evidence available to assess impact in terms of use of and benefit from the youth-focused prevention activities. Work to conduct a youth SUD care continuum needs assessment and to develop a strategic plan was not completed. Taken together, these findings suggest that youth-focused upstream prevention is an area in need of future investment.

Upstream prevention training opportunities largely centered on pain management and safe prescribing practices. To promote equitable access, grantees removed financial barriers for priority populations (e.g., scholarships for conference fees); included tribal leadership, Spanish-speaking health providers, and communities of color in planning efforts; and included people with lived experience with SUD in developing materials and resources. Moreover, one conference was culturally-specific intended to support Tribal Best Practices. These grantees also offered evidence of utilization, which suggested that thousands of people participated in these trainings, and most participants were satisfied with training content. There was not enough evidence available to assess equitable outcomes for participants.

The Strategic Planning Initiative involved engaging community stakeholders and leaders to conduct a needs assessments and develop strategic plans for integrating the SUD care continuum and public health. Timelines for implementing the plans are now being developed.

SOR2 Grant Evaluation Key Findings

Portland State University (PSU) evaluated the overall impact of SOR2 funding (September 2020 – September 2022). The evaluation, which aligned with Oregon Health Authority's (OHA) focus on health equity, had three core components: (1) successes and challenges associated with implementation and sustainability, (2) collaboration efforts to support SOR2-funded activities, and (3) impact on expanding access to SUD services and supports. Here we summarize the key evaluation findings for each component, and offer recommendations for future investments in Oregon's substance use disorder (SUD) system.

Despite challenges, most grantees implemented their planned SOR2 activities within the funding period.

- **Grantees were flexible, creative, and resourceful** in responding to unexpected challenges, especially related to the pandemic (e.g., supply chain disruptions, higher cost of supplies, workforce shortages).
- **Having time and resources for implementation planning** supported grantees' readiness for service delivery. It also allowed grantees to design processes and practices that promote equity (e.g., more inclusive planning with communities most affected by the impact of SUD, offering culturally relevant services, removing barriers to accessing services). Many grantees needed more resources than they anticipated, especially those implementing new services.
- **Implementation successes reflected organizational strengths that grantees brought to their SOR2-funded activities.** Collaboration (within the organization and with external partners), using information (e.g., data, constituent feedback) to design improvements, and having supportive leadership contributed to implementation successes.
- **Implementation challenges were largely related to staffing and developing infrastructure to support service delivery**. Hiring and turnover presented challenges because of the statewide shortage in the behavioral health workforce, employees missing work due to illness and quarantining, and pandemic-related mental health impacts. Developing workflows, policies, and procedures to accommodate new or expanded services took time, especially related to compliance with billing regulations (e.g., credentialing, billing codes, negotiating fees).

Collaboration was an important short-term outcome of SOR2-funded activities.

- **Semi-formal and formal collaborations were important** in carrying out SOR2-funded activities.
- **Collaboration was a pathway** for grantees to expand access to and improve quality of SOR2-funded activities. Some collaboration efforts were mutually-beneficial for both partners, a feature that can promote equity.
- **Collaboration contributed to strengthening Oregon's SUD system** by increasing the number of partnerships between SUD treatment, MAT, behavioral health, harm reduction services, and recovery organizations, and through efforts to integrate services.

SOR2 funding expanded the availability and utilization of SUD resources in Oregon.

Based on grantees' bi-annual progress reports and other supporting materials, PSU found evidence of progress made toward SOR2-funded strategic goals despite challenges posed by the COVID-19 pandemic and a statewide SUD workforce shortage. There was comparatively more evidence available to evaluate expanded availability than utilization of SUD resources.

- **SOR2 funding substantially influenced SUD recovery support services in Oregon**. Grantees reported an increase in the availability of recovery meetings, housing support, recovery events, recovery coaching, peer mentoring, and employment or educational support. More than 7,800 clients received recovery support services during the SOR2 funding period, and available evidence suggests that many reduced their substance use, increased their recovery capital, and improved their quality of life. There was also evidence that SOR2 promoted equitable access to recovery services by funding culturally-specific community organizations and identifying and serving priority populations, but there was less evidence available to evaluate equitable recovery outcomes.

- **SOR2 funding contributed to expanding Oregon's SUD workforce by creating new professional development and hiring opportunities.** Workforce development grantees provided trainings that met credentialing requirements, and there was evidence of training participation and completion, and in some cases, benefits accrued from participation (e.g., obtained credentials). SOR2 funding increased the availability of training opportunities for priority populations in rural/frontier areas, individuals with Spanish as their preferred language, and the peer workforce. There was insufficient evidence available to assess whether participants experienced equitable professional development outcomes.

  SOR2 funding also expanded the SUD workforce was through hiring, training new and existing staff, and promotion. Despite challenges, grantees hired new, and upskilled existing, staff to carry out SOR2-funded activities. There were efforts to diversify the SUD workforce to serve communities most often marginalized and/or underserved more effectively, and evidence that SOR2 funding helped expand the peer workforce in Oregon. It was not clear whether these efforts promoted equitable hiring and training outcomes.

- **SOR2 funding expanded the availability of harm reduction and overdose prevention supplies, training, and supports in Oregon.** Save Lives Oregon, a resource hub to provide naloxone and other life-saving supplies to organizations and tribal communities, had a substantial impact on the SUD system in Oregon. Harm reduction and overdose prevention grantees expanded efforts to increase outreach to their communities, with explicit focus on communities most underserved and disinvested, and provided training and TA to increase awareness of the Naloxone Clearinghouse and reduce stigma associated with harm reduction. Collectively, SOR2 grantees reported thousands of overdose reversals in their catchment areas during the SOR2 funding period, millions of syringes exchanged, and hundreds of people tested for infectious diseases. However, there was not enough evidence to assess whether clients experienced equitable harm reduction outcomes.

- **SOR2 funding had an impact on expanding the availability of SUD treatment.** SOR2 funding supported the expansion of MAT and CM services in rural counties, as well as treatment services

for prenatal and postpartum parents, culturally-specific treatment models, and an innovative digital/virtual treatment practice. Many grantees had goals for expanding access to SUD treatment services for priority populations. During the SOR2 funding period, more than 4,900 clients received OUD treatment and nearly 900 received stimulant use disorder treatment. Available evidence suggested positive impacts for clients related to engagement in peer services, prenatal care and well-child checks, treatment retention, reduced alcohol and drug use, increased quality of life, and improved health. However, there was little evidence available to evaluate equitable service delivery and outcomes for priority populations.

- **SOR2 funding supported the development of curriculum, training opportunities, and strategic plans for preventing SUD.** Grantees developed resources for youth SUD prevention and plans to strengthen the SUD care continuum in rural communities. Training opportunities largely centered on pain management and safe prescribing practices. To promote equitable access, grantees removed financial barriers to participation for priority populations and worked to be inclusive in their planning efforts. Thousands of people participated in these trainings and evidence suggests that most were satisfied with the content, although there was not enough evidence to assess equitable training outcomes.

Recommendations for Future Investments in Oregon's SUD System

Based on findings from the SOR2 Impact Evaluation, we offer the following recommendations for future investments in Oregon's SUD system.

- **Fund culturally-specific organizations**. Building on progress made during the SOR2 funding period, especially among grantees providing recovery support services, it is important to continue funding culturally-specific organizations to promote equitable client/participant outcomes.[17] Redistributing resources and power to culturally-specific organizations has potential to repair harm done by systemic racism in the health system, a goal in alignment with OHA's commitment to health equity. Other capacity-building investments might include funding collaborations between culturally-specific organizations and financial sponsors, consultants, grant writers, or evaluators.

  Funding **culturally-specific workforce development grantees**, or grantees with diverse trainers offering culturally-derived or -responsive curriculum, and/or training opportunities in multiple languages could better prepare the SUD workforce and attract more diverse participants.[18]

- **Fund grantees to develop their capacity for data collection, tracking, analysis, and evaluation**. Although many grantees had a system for collecting data and tracking their service activities, there was comparatively less data available to examine utilization, or the use of and benefit from services. This is particularly important for disaggregating data to assess progress made toward equitable access and outcomes. If equity is a priority, grantees need support in developing their capacity to collect and analyze data, and design strategies for improvement.

- **Continue to identify priority populations** and incentivize grantees to develop specific strategies to expand access to and utilization of resources. Through targeted recruitment, many SOR2-funded activities expanded access to SUD resources for people living in disinvested communities (e.g., rural areas), communities of color (e.g., Latine/Hispanic), and other groups who face marginalization by the health system. Intentionally identifying and funding services for priority populations can promote equitable access, encourage agencies to set specific equity goals, and provide culturally- and linguistically-responsive services.

- **Encourage the involvement of people with lived experience**. In alignment with SAMHSA's *Participation Guidelines for Individuals with Lived Experience and Family*, encourage grantees to

[17] Curry-Stevens, A., Deloney, G., & Morton, M. (2019). Rethinking Services with Communities of Color: Why Culturally Specific Organizations Are the Preferred Service Delivery Model. *Sociology Mind, 9*, 183-206. https://doi.org/10.4236/sm.2019.93013

[18] Scheyer, K., Gilchrist, E., Muther, J., Hemeida, S., & Wong, S.L. (April, 2019). *Recruitment and Retention Recommendations for Oregon's Behavioral Health Workforce.* Farley Health Policy Center. https://www.oregon.gov/oha/HPA/HP-HCW/Documents/Recruitment-Retention-Recs-%20Oregon-BH%20Workforce-April-2019.pdf

involve peers/people with lived experience in designing their services, including client outreach, engagement, and retention. Incentivize agencies to collect client feedback on their experiences with services to better assess whether they are culturally-responsive, trauma-informed, and person-centered, and areas for improvement.

- **Provide resources for grantees to engage in collaboration and implementation activities**. Collaboration and implementation activities are critical for service delivery, expanding access to SUD resources, and strengthening the SUD system in Oregon. However, these activities require resources that some organizations do not have, thereby disadvantaging, for example, smaller organizations with fewer revenue channels. In addition to funding, provide grantees with access to TA, consultation, and peer learning communities to support their collaboration and implementation work. It is also important for funding to have the explicit goal of redistributing access to resources to culturally-specific organizations and communities.

- **Support grantees in navigating state and federal policies and regulations, and advocate for any needed changes.** It was challenging for many grantees to navigate and comply with credentialing and certification requirements, particularly as they pertain to Medicaid and private insurance billing regulations. To support grantees, it would be helpful to offer training, consultation, peer learning opportunities, and advocacy related to state and federal policies that impact their SUD work.

- **Extend the SOR funding period**. Two-year funding cycles are challenging for grantees, especially those implementing new interventions. Longer funding periods, along with more expedient contracting, would allow grantees more time to plan, install, implement, and build evidence for the impact of their funded activities.

- **Support grantees in sustainability planning**. Support grantees in in planning for sustainability in terms of diversifying funding streams (including Medicaid), scaling up interventions, developing infrastructure to support service delivery, and workforce development. Like implementation, it is important to provide TA, consultation, and opportunities for peer learning to support sustainability planning. Grantees using Medicaid to sustainably fund services need more support navigating billing regulations, data systems, and information sharing.

- **Increase grant funding to accommodate increased wages and benefits**. Often the benefits of credentials, such as job opportunities or wages, are not commensurate with the cost of attaining and maintaining the credentials.[19] Moreover, rising inflation, housing costs, and workforce shortages have placed increased demand on agencies to offer more competitive wages. Future funding should accommodate the increasing costs of recruiting, training, and retaining qualified staff.

[19] Dill, J., Morgan, J. C., Van Heuvelen, J., & Gingold, M. (2022). Professional certification and earnings of health care workers in low social closure occupations. *Social Science & Medicine*, *303*:115000. https://doi:10.1016/j.socscimed.2022.115000

Appendix A. Clients Receiving Treatment & Recovery Services, and Overdose Reversals

Tables 1 – 4 include the total number of unduplicated clients receiving various services during this SOR2 funding period (reported by 30 grantees).

Table 1: Number of unduplicated clients who received treatment services for Opioid Use Disorder (OUD)

	9/30/20 – 3/31/21	4/1/21 – 9/29/21	Year 1 Total	9/30/21 – 3/31/22	4/1/22 – 9/29/22	Year 2 Total	Project Total
Number of **unduplicated** clients who received OUD treatment services	240*	707	**947**	2,344*	1,671	**4,015**	**4,962**
i. Number received Methadone	180	96	**276**	1,356*	634	**1,990**	**2,266**
ii. Number received Buprenorphine	52*	563	**615**	785*	443	**1,228**	**1,843**
iii. Number received Injectable Naltrexone	8*	21	**29**	41	26	**67**	**96**

* Updated after grantees revised their Y1 or Y2 mid-year counts.
Note: The number of clients who received OUD medications does not equal the number of **unduplicated** clients because some clients did not receive medication as part of their OUD treatment.

Table 2: Number of unduplicated clients who received treatment services for stimulant use disorder

	9/30/20 – 3/31/21	4/1/21 – 9/29/21	Year 1 Total	9/30/21 – 3/31/22	4/1/22 – 9/29/22	Year 2 Total	Project Total
Number of **unduplicated** clients who received treatment services for stimulant use disorder	65	68	**133**	252*	511	**763**	**896**

* Updated after grantees revised their Y2 mid-year counts.
Note: These clients are not mutually exclusive from those receiving OUD treatment reported in Table 1.

Table 3: Number of unduplicated clients who received recovery support services

	9/30/20 – 3/31/21	4/1/21 – 9/29/21	Year 1 Total	9/30/21 – 3/31/22	4/1/22 – 9/29/22	Year 2 Total	Project Total
Number of **unduplicated** clients who received recovery support services	393	1,718	**2,111**	3,276*	2,469	**5,745**	**7,856**
i. Recovery Housing	80	334	**414**	1,014*	707	**1,721**	**2,135**
ii. Recovery Coaching or Peer Coaching	322	1,505	**1,827**	2,271*	1,818	**4,089**	**5,916**
iii. Employment Support	81	105	**186**	119	136	**255**	**441**

* Updated after grantees revised their Y2 mid-year counts.

Note: Types of recovery support services do not always add up to the total number of unduplicated clients because some clients received more than one type of recovery support service.

Table 4: Number of overdose reversals

	9/30/20 – 3/31/21	4/1/21 – 9/29/21	Year 1 Total	9/30/21 – 3/31/22	4/1/22 – 9/29/22	Year 2 Total	Project Total
Number of overdose reversals (client or police reported, non-fatal)	45	876	**921**	1,127	676*	**1,803**	**2,724**

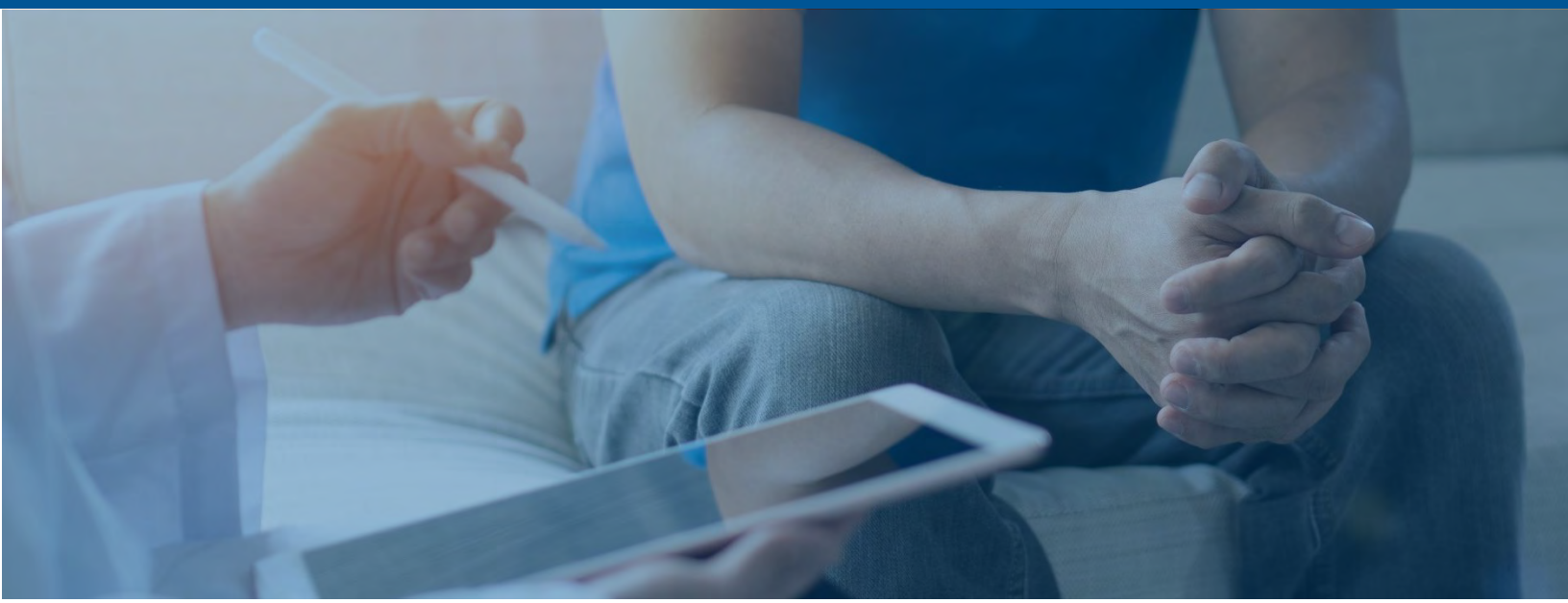
*Overdose reversals were reported only if collected at naloxone distribution or refill.

Appendix B. RMC Research: Oregon State Opioid Response-2 Evaluation Report, October 2022

Oregon State Opioid Response-2

EVALUATION REPORT

October 2022



Prepared by

Paul Smokowski
Al Chiappone
Addy Grohs
Grace Lewandowski
RMC Research Corporation
111 SW Columbia Street, Suite 1030
Portland, OR 97201

Prepared for

Oregon Health Authority
Health Systems Division
500 Summer Street NE
Salem, OR 97301-1079

In 2020 the Oregon Health Authority (OHA) received State Opioid Response-2 (SOR-2) grant funding from the U.S. Department of Health and Human Services' Substance Abuse and Mental Health Services Administration (SAMHSA).

Key aspects of the SOR-2 grant include increasing access to medication assisted treatment; reducing unmet treatment need; and reducing opioid overdose related deaths through the provision of prevention, treatment, and recovery activities related to opioid use disorder (OUD). Across Oregon, 51 SOR-2 subgrantees are currently providing treatment or recovery services to people with opioid use disorder. These subgrantees administer the funder required Government Performance Results Act (GPRA) client interview at program intake, 6-month follow up, and discharge. An additional set of subgrantees implement naloxone distribution and overdose prevention education to reduce the overall number of opioid overdoses and decrease opioid overdose mortality rates.

This report describes the evaluation activities, reports findings regarding client functioning at intake to SOR-2 funded services, summarizes changes in indicators from intake to 6-month follow-up, identifies any problems encountered and plans for resolution, and presents evaluation conclusions. The reporting timeframe for this report is October 1, 2021, to September 30, 2022.

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EVALUATION ACTIVITIES

This section details the evaluation activities related to project coordination, assistance to subgrantees around data collection, data management, and reporting from October 1, 2021, through September 30, 2022.

Task 1: RMC Project Coordination

- Communicated regularly by email and phone with OHA to coordinate GPRA trainings with newly contracted subgrantees, shared updates on naloxone data collection and reporting, and discussed other evaluation activities.
- Participated in monthly phone meetings with the SOR project director.
- Participated in regular SAMHSA project officer calls with OHA.
- Submitted an IRB amendment to receive GPRA data from Recovery Link.

Task 2: RMC Assistance Around Data Collection

GPRA Data Collection

- Provided materials to subgrantees via Dropbox.
- Scheduled and conducted live training webinars for subgrantees.
- Conducted online trainings for subgrantees.
- Provided ongoing technical assistance through emails and calls with subgrantees.
- Provided technical assistance to sites on when to use the “none of the above/don’t know” response options for Section A, behavioral health diagnoses.
- Contacted sites who used “none of the above” for updated behavioral health diagnoses and entered into SPARS.
- Offered monthly 6-month/discharge trainings for standard grantees and 6-month trainings
- Offered weekly technical assistance drop-in sessions for standard sites and prime+ sites (separate sessions).

Naloxone Progress Report Data Collection

- Collected quarterly data for progress reporting to OHA and quarterly data related to federally required data collection (SAMHSA's program instrument).
- Submitted quarterly data dashboards and graphical data summaries to OHA.

Task 3: Data Management

- Entered GPRAs into SAMHSA's Performance Accountability and Reporting System (SPARS) database.
- Provided weekly dashboards to OHA reflecting number of intakes for each subgrantee.
- Provided subgrantees with weekly "6-month GPRA window is open" reminders.
- Shipped 6-month GPRA interview gift cards incentives to subgrantees.
- Provided ongoing technical assistance to subgrantees to ensure GPRAs are administered correctly.
- Provided sites with comprehensive report of all intake and 6-month GPRAs completed so sites can compare RMC's records to the site's records (therefore ensuring that RMC has complete record of GPRAs).

Task 4: Process Evaluation

- Developed a tracking tool to capture subgrantee transitions from SOR to SOR-2.

Task 5: Outcome Evaluation

- Conducted analyses of GPRA interview data for the current report and report submitted in October 2021 and April 2022.

Task 6: Reporting

- Submitted bimonthly progress reports.

EVALUATION METHODS

OVERVIEW

This outcome evaluation presents findings from Government Performance and Results Act (GPRA) interview data collected by SOR2 subgrantees. Client findings are aggregated across 51 subgrantees that conducted GPRA interviews. **This report describes data collected and processed between October 1, 2021, and September 30, 2022.** Clients are asked to take part in the GPRA interview at intake into the SOR-funded program, 6 months after intake, and at discharge.

PARTICIPANTS AND DATA COLLECTION

Between October 1, 2021, and September 30, 2022, 1,900 clients completed GPRA intake interviews. Of those, 1885 (99%) signed a consent form to participate in RMC Research's evaluation. A total of 583 clients completed a 6-month GPRA interview and 580 (99%) signed a consent form. However, 3% of these interviews were conducted prior to (2%) or after (1%) the SAMHSA specific follow-up window and are excluded from this report. Overall, 38% of clients eligible for the 6-month GPRA interview completed the interview (561 of 1,485) during the SAMHSA specific follow-up window. For 30% (345 of the 1,151) of clients eligible for a 6-month GPRA interview, the follow-up window was still open at the time data were pulled for this report. Lastly, 43 clients participated in a discharge interview.

ANALYSIS

This report describes the **full SOR sample at intake (n=1,885)** and summarizes the **changes in indicators from intake to 6-month follow-up (n=561)** to answer the evaluation questions related to client progress. Analysis of changes in indicators from intake to 6-months is restricted to clients who completed the intake interview and the 6-month GPRA interview within the SAMHSA specific follow-up window. Clients can refuse to answer questions in the GPRA interview or indicate that they do not know the answer. For each indicator, *refused* and *don't know* were recoded as missing and not included in analyses, thus sample sizes vary. The following table presents indicators included in this evaluation report and analysis methods.

ANALYSIS METHODS

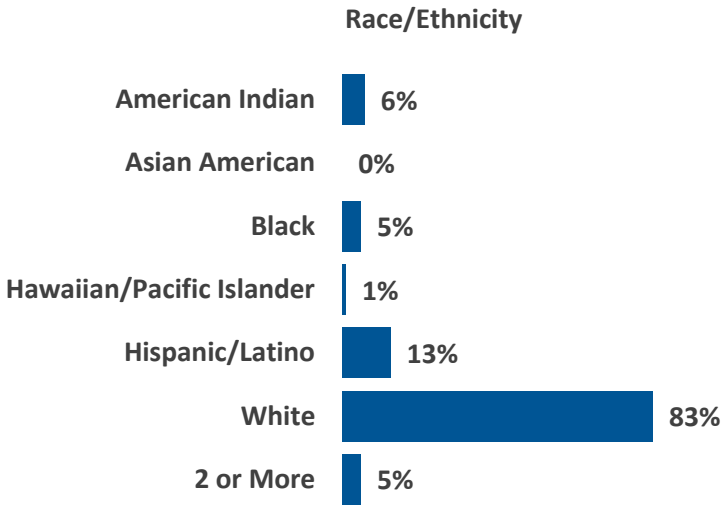
Indicator	Sample Size and Analysis
Demographics: Gender, race/ethnicity, education level, pregnancy status, children, lost parental rights, and children living with someone else	Intake descriptive statistics (*n* = 856 to 1,883)
FDA Approved Medications Received for OUD: Buprenorphine, Methadone, Naltrexone, extended-release Naltrexone, and no medication	Intake descriptive statistics (*n* = 582 to 998)
Illicit Opioid and Other Drug Use: Alcohol, opioid (e.g., heroin, Oxycontin/oxycodone), and other illegal drug use	Intake descriptive statistics (*n* = 337 to 1,885) Changes from intake to 6 months (*n* = 505 to 519)
Living Conditions: Place of residence and satisfaction with living space	Intake descriptive statistics (*n* = 1,403 to 1,859) Changes from intake to 6 months (*n* = 410 to 548)
Education and Income: Enrollment in school or job training program, employment status, and enough money to meet needs	Intake descriptive statistics (*n* = 1,619 to 1,862) Changes from intake to 6 months (*n* = 453 to 534)
Crime and Criminal Justice: Arrests, nights in jail, probation, or parole, awaiting charges, trial or sentencing	Intake descriptive statistics (*n* = 119 to 1,845) Changes from intake to 6 months (*n* = 383 to 544)
Physical Health: Reception of inpatient, outpatient, and emergency room treatment, HIV testing, knowledge of HIV test results, health rating, satisfaction with health, ability to perform daily activities, enough money for everyday life, and quality of life	Intake descriptive statistics (*n* = 1,485 to 1,858) Changes from intake to 6 months (*n* = 418 to 541)
Mental Health and Adverse Effects: Anxiety, depression, stress, emotional problems, and reduction of activities due to alcohol or other drug use, and psychological or emotional issues	Intake descriptive statistics (*n* = 1,269 to 1,834) Changes from intake to 6 months (*n* = 166 to 526)
Social Connectedness: Attendance of non-religious and non-religious/faith-based self-help groups, supportive interactions, someone to turn to when in trouble	Intake descriptive statistics (*n* = 1,814 to 1,851) Changes from intake to 6 months (*n* = 530 to 543)

Intake descriptive statistics included counts, percentages, and means using the entire intake sample (*n* = 1,885). Changes from intake to 6-months included paired t-test, chi-square tests, analysis of variance and post-hoc tests using the longitudinal sample (*n* = 561) of clients who completed the intake interview and the 6-month GPRA interview within the SAMHSA specific follow-up window. The level of significance for all analyses was set at $p \leq 0.05$.

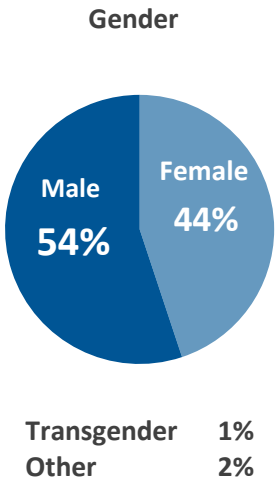
DEMOGRAPHICS

Most clients served by programs are White (83%), followed by Hispanic/Latino (13%), American Indian (6%), and Black (5%). Most (54%) of clients are male. Almost one quarter of clients (23%) do not have formal education and less than half (48%) have a high school diploma or GED.

RACE/ETHNICITY AND GENDER



1,773 – 1,883



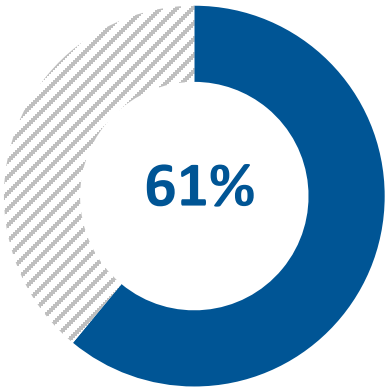
1,861

EDUCATION LEVEL

1,859

CHILDREN AND PREGANCY STATUS

Overall, 61% of clients have children, with an average of 2.3 children. Of those clients, 21% have lost parental rights and 19% have children living with someone else due to a court order. A small minority (9%) of female or transgender clients are pregnant.



of clients have children

1,840

Number of Children

2.3 average number of children

Parental Rights

21% of clients have lost parental rights

Court Order

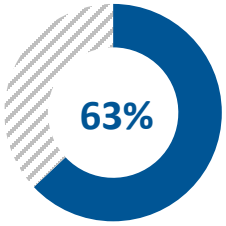
19% of clients have children living with someone else due to a court order

Sample sizes: Average number of children (*n* = 1,088), parental rights (*n* = 880), court order (*n* = 1,088).

OPIOID USE DISORDER AND MEDICATIONS

At intake, 63% of clients were diagnosed with opioid use disorder in the past 30 days. The majority (61%) of these recently diagnosed clients received buprenorphine for treatment of opioid use disorder and 17% did not receive medication.

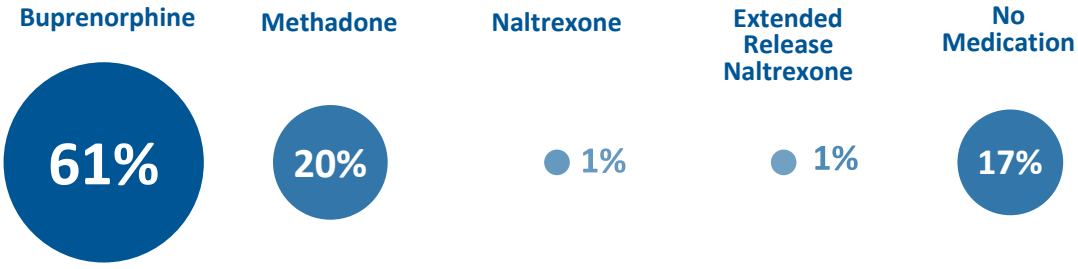
CLIENTS DIAGNOSED WITH OPIOD USE DISORDER



recently diagnosed with opioid use disorder

998

FDA APPROVED MEDICATION RECEIVED FOR OPIOID USE DISORDER



582

ALCOHOL AND SUBSTANCE USE

Intake

At intake, **27% of clients reported illicit opioid drug use** in the past 30 days. Among these clients, **heroin was the most used opiate**, with 88% reporting past 30-day use on an average of 15.6 days. Oxycontin/oxycodone was the second most used opiate, with 16% reporting past 30 days use on an average of 2.0 days. Seventy-two percent **of clients reported opioid, and methamphetamine use** during the same 30-day period on an average of 16.3 days. **Twenty-three percent of clients reported past 30-day drug injection and of those 34% used injection equipment someone else used.**

Changes from Intake to 6 Months

Clients reported a **significant decrease in past 30-day alcohol use (2.9 to 1.3 days) illegal drug use (10.1 to 5.7 days)** between intake and 6 months. Between intake and 6 months, clients also reported a **significant decrease in past 30- day Heroin (4.0 to 1.0 days), OxyContin/Oxycodone (0.6 to 0.1 days), Methamphetamine (3.5 to 2.5 days), Marijuana/Hashish (4.0 to 2.8 days), Benzodiazepines (0.6 to 0.2 days) Cocaine/crack (0.3 to 0.1 days), and other illegal drug (2.7 to 1.5 days) use**. The percentage of clients reporting injecting drugs in the past 30 days significantly decreased from intake (19%) to 6 months (9%). Comparisons in the use of injection equipment someone else used were not computed due to small sample sizes.

OPIOID USE SNAPSHOT AT INTAKE

Past 30-Day Opioid Use

27% of clients reported illicit opioid use

Past 30-Day Drug Injection

23% of clients reported drug injection

Among these clients

- 88% reported heroin use, averaging 15.6 days
- 16% reported Oxycontin/oxycodone use, averaging 2.0 days
- 72% reported concurrent opioid and methamphetamine use in the same 30-day periods, averaging 16.3 days

Sample sizes: opioid use (*n* = 1,885), drug injection (*n* = 1,783), percent and mean heroin use (*n* = 504), percent and mean Oxycontin/oxycodone use (*n* = 502), percent and mean concurrent opioid and methamphetamine use (*n* = 503; n=363).

AVERAGE PAST 30-DAY USE AMONG ALL CLIENTS

	Entire intake sample	Changes from intake to 6 months (matched)	
Past 30 Day Drug and Alcohol Use	**Intake (*n* = 337-1,829)**	**Intake (*n* = 505-519)**	**6 Month (*n* = 505-519)**
Alcohol*	**2.7**	**2.9**	**1.3**
Illegal drugs*	**11.8**	**10.1**	**5.7**
Alcohol and drugs on same day	**7.2**	**--**	**--**
Opiates			
Heroin*	**4.4**	**4.0**	**1.0**
OxyContin/Oxycodone*	**0.6**	**0.6**	**0.1**
Percocet	**0.2**	**0.1**	**0.0**
Morphine	**0.2**	**0.1**	**0.0**
Methamphetamine*	**5.3**	**3.5**	**2.5**
Marijuana/Hashish*	**5.2**	**4.0**	**2.8**
Benzodiazepines*	**0.4**	**0.6**	**0.2**
Cocaine/Crack*	**0.3**	**0.3**	**0.1**
Other illegal drugs*	**3.5**	**2.7**	**1.5**

*Significant at $p \leq 0.05$. Illicit drugs with an average less than or equal to 0.1 days at intake are excluded from the table and include: Tylenol 2, 3, 4, Codeine, Non-prescription methadone, Dilaudid, Darvon, Demerol, Non-prescription GHB, hallucinogens, Ketamine, other tranquilizers, and Inhalants. Blank cells are due to low sample size, predominately due to appropriate skip patterns.

LIVING CONDITIONS

Intake

At intake **77% of clients reported being housed**, followed by street/outdoors (11%), shelter (7%), and institution (5%). Of the clients who reported being housed, **46% own or rent**, 28% stayed at someone else's place, 9% were in residential treatment, 5% halfway house, and 12% other housing. Overall, 27% of clients reported being satisfied or very satisfied with their living conditions.

Changes from Intake to 6 Months

The number of clients who reported being housed did not significantly change from intake (84%) to follow-up (83%). Of the clients who reported being housed, **clients who owned/rented an apartment significantly increased from intake (55%) to 6 months (59%).** Client's reported significant declines in their satisfaction with living conductions.

LIVING CONDITIONS

	Entire intake sample	Changes from intake to 6 months (matched)	
Past 30-Day Living Conditions	**Intake (*n* = 1,403-1,859)**	**Intake (*n* = 410-548)**	**6 Month (*n* = 410-548)**
Place of residence			
Housed	77%	84%	83%
Own/rent apartment*	46%	55%	59%
Someone else's apartment	28%	23%	23%
Residential treatment	9%	5%	6%
Halfway house	5%	5%	6%
Other	12%	8%	8%
Shelter	7%	7%	5%
Street/outdoors	11%	5%	7%
Institution	5%	3%	2%
Satisfaction with living conditions*			
Very dissatisfied	18%	21%	25%
Dissatisfied	41%	46%	48%
Neither dissatisfied nor satisfied	14%	13%	12%
Satisfied	13%	11%	8%
Very satisfied	14%	10%	8%

*Significant at $p \leq 0.05$. Percentages may not add up to 100% due to rounding.

EMPLOYMENT AND INCOME

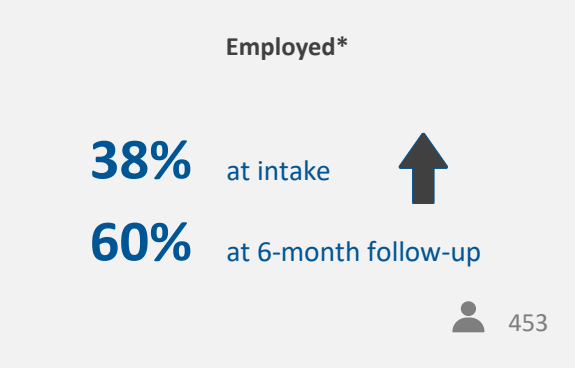
Intake

In terms of employment, at intake **34% of clients reported being employed**, either full time (23%) or part time (10%). At intake, 39% of clients reported having completely (9%), mostly (16%), or moderately (14%) enough money to meet their needs. Almost all (94%) clients were not enrolled in a school or job training program.

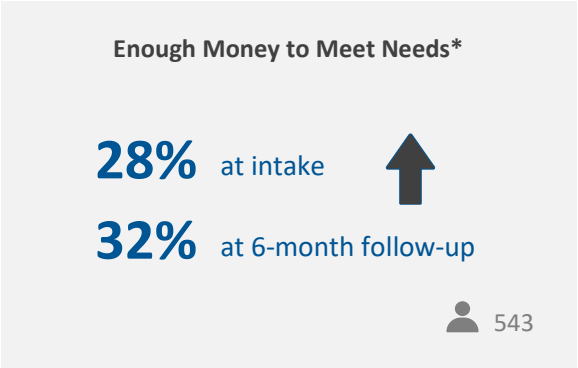
Changes from Intake to 6 Months

Significantly more clients reported being employed (either full or part time) from intake (38%) to 6 months (60%). Clients also reported a **significant increase in having enough money to meet their needs** from intake (28%) to 6 months (32%). Clients reported an increase in part-time and full-time enrollment in a school or job training program from intake (7%) to 6 months (10%), but the increase was not statistically significant.

EMPLOYMENT STATUS AND PERCEPTION OF INCOME



*Significant at $p \leq 0.05$. Disabled, other, and retired were exluded. Graphic displays matched sample.



*Significant at p ≤ 0.05. Ascertained collapsed (completely, mostly, moderately) and not ascertained collapsed (a little, not at all). Graphic displays matched sample.

Enrollment in a school or job training program

Intake (*n* = 1,857)	Matched Intake (*n* = 543)	Matched 6 Months (*n* = 543)
▸ Not enrolled: 94%	▸ Not enrolled: 92%	▸ Not enrolled: 90%
▸ Full time: 3%	▸ Full time: 4%	▸ Full time: 6%
▸ Part time: 2%	▸ Part time: 3%	▸ Part time: 4%
▸ Other: 1%	▸ Other: 1%	▸ Other: 1%

CRIME AND CRIMINAL JUSTICE

Intake

At intake, clients reported being arrested on an average of 0.9 times in the past 30 days. Among those clients, the average number of times arrested for a drug related offense was 0.4 times. Overall, **clients spent an average number of 1.4 nights in jail/prison** in the past 30 days. Finally, 29% of clients were on parole or probation and 16% were awaiting charges, trial, or sentencing at intake.

Changes from Intake to 6 Months

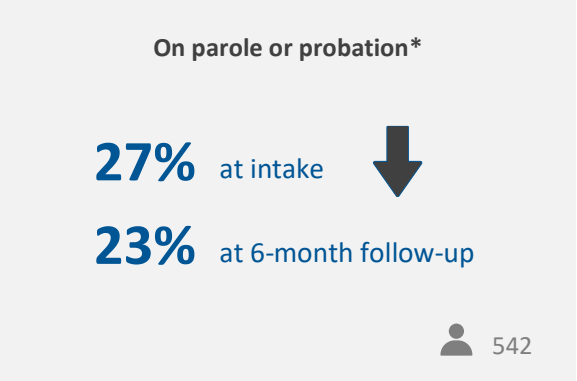
Clients did not report changes in the number of times arrested in the past 30 days from intake to 6 months. **Clients reported a significant decrease in the number of nights spent in jail/prison from intake (1.3 days) to 6 months (0.6 days).** A significant decrease in clients on probation or parole (27% to 23%) and clients awaiting charges, trial, or sentencing (15% to 9%) from intake to 6 months was detected.

CRIME AND CRIMINAL JUSTICE

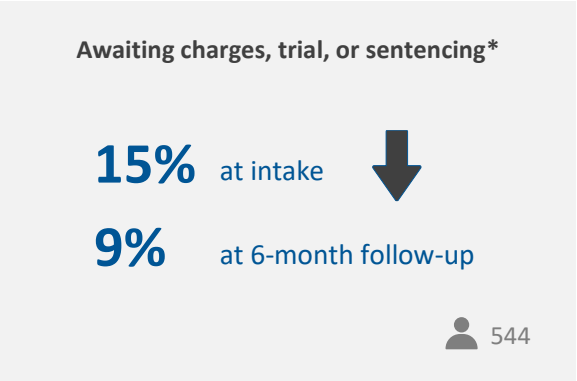
	Entire intake sample	Changes from intake to 6 months (matched)	
Past 30 Day Crime and Criminal Justice	**Intake (*n* = 119-1,814)**	**Intake (*n* = 383-506)**	**6 Month (*n* = 383-506)**
Arrested	0.9	0.1	0.0
Arrested for drug-related offense	0.4	--	--
Nights spent in jail/prison*	1.4	1.3	0.6

Cells present average number of times in the past 30 day period. Blank cells are due to low sample size, predominately due to appropriate skip patterns.

CORRECTIONS



*Significant at $p \leq 0.05$. Graphic displays matched sample.



*Significant at $p \leq 0.05$. Graphic displays matched sample.

PHYSICAL HEALTH

Intake

Alcohol or substance abuse treatment was the most common form of treatment that clients received in the past 30 days for inpatient (17%) and outpatient (46%) treatment settings. Additionally, 43% of clients rated their health as fair or poor; 51% were dissatisfied or very dissatisfied with their health; 57% were dissatisfied or very dissatisfied with their ability to perform daily activities; and 18% rated their quality of life as very poor or poor. With regards to HIV testing, **83% reported having been tested for HIV and of those clients 96% knew the results of their test**.

Changes from Intake to 6 Months

Fewer clients reported receiving alcohol or substance use treatment in inpatient treatment settings from intake (16%) to 6 months (4%). However, this change was not statistically significant. There were significant declines in how clients rated their satisfaction with their health and satisfaction with their ability to perform daily activities from intake to 6 months. Clients reported significant increases in having enough energy for everyday life, quality of life, and health rating from intake to 6 months. **Significantly more clients had been tested for HIV from intake (84%) to 6 months (89%).** No changes in knowing the results of the HIV test were detected.

TREATMENT

	Entire intake sample	Changes from intake to 6 months (matched)	
Past 30 Reception of Treatment	**Intake (*n* = 1,783-1,826)**	**Intake (*n* = 504-516)**	**6 Month (*n* = 504-516)**
Inpatient treatment			
Physical complaint	6%	6%	4%
Mental or emotional difficulties	4%	5%	1%
Alcohol or substance use	17%	16%	4%
Outpatient treatment			
Physical complaint	11%	11%	14%
Mental or emotional difficulties	11%	11%	14%
Alcohol or substance use	46%	36%	34%
Emergency room treatment			
Physical complaint	12%	12%	9%
Mental or emotional difficulties	4%	5%	2%
Alcohol or substance use	9%	6%	2%

*Significant at $p \leq 0.05$. Percentages may not add up to 100% due to rounding.

HEALTH RATING AND QUALITY OF LIFE

	Entire intake sample	Changes from intake to 6 months (matched)	
Health and Quality of Life	**Intake (*n* = 1,839-1,858)**	**Intake (*n* = 533-541)**	**6 Month (*n* = 533-541)**
Health rating*			
Poor	14%	12%	9%
Fair	29%	23%	20%
Good	40%	43%	50%
Very good	13%	15%	15%
Excellent	5%	7%	7%
Satisfaction with health*			
Very dissatisfied	7%	9%	11%
Dissatisfied	44%	50%	50%
Neither satisfied nor dissatisfied	23%	20%	22%
Satisfied	18%	16%	13%
Very satisfied	8%	6%	4%
Ability to perform daily activities*			
Very dissatisfied	11%	11%	16%
Dissatisfied	46%	51%	52%
Neither satisfied nor dissatisfied	20%	17%	17%
Satisfied	16%	16%	11%
Very satisfied	6%	5%	4%
Enough energy for everyday life*			
Not at all	14%	12%	9%
A little	18%	19%	14%
Moderately	23%	22%	23%
Mostly	31%	35%	37%
Completely	14%	13%	16%
Quality of life*			
Very poor	5%	4%	3%
Poor	13%	11%	9%
Neither poor nor good	29%	26%	21%
Good	42%	46%	48%
Very good	11%	13%	18%

*Significant at $p \leq 0.05$. Percentages may not add up to 100% due to rounding. Cell sample sizes were too small for categorical analysis and thus Likert scale treated as a numeric value.

MENTAL HEALTH AND ADVERSE EFFECTS

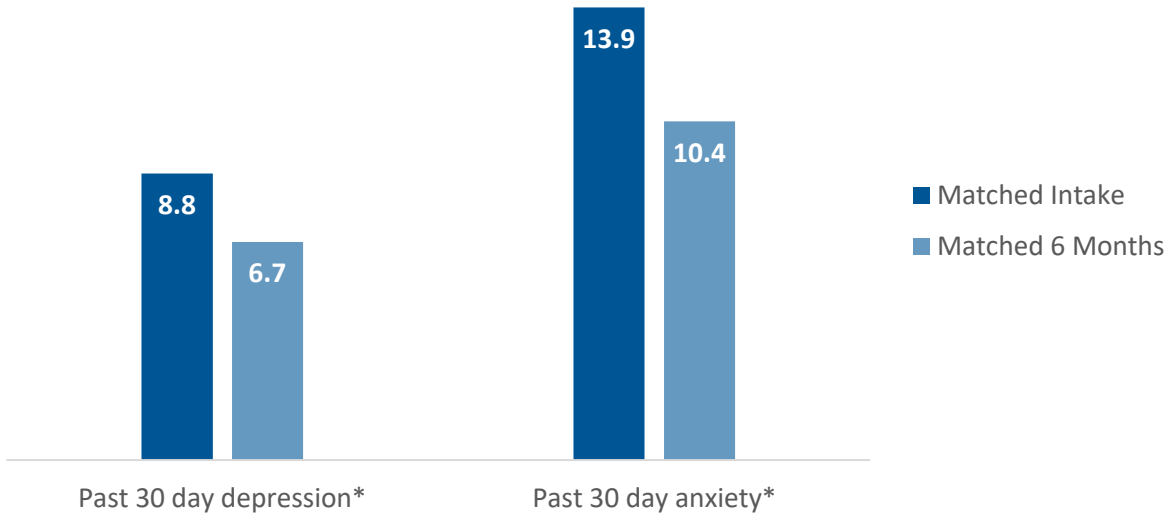
Intake

At intake, **56% of clients reported experiencing serious depression during the past 30 days**, with an average 9.4 days. **Reported anxiety was higher with 70% clients reported experiencing anxiety in the past 30 days**, with an average of 13.4 days. Additionally, clients experienced stress (85%), emotional problems (80%), and reduced or gave up activities (71%) due to alcohol or other drug use in the past 30 days. Most clients (85%) reported being bothered by psychological problems to some degree.

Changes from Intake to 6 Months

Clients reported **significantly fewer days experiencing serious depression (8.8 to 6.9 days) and anxiety (13.9 to 10.4 days) during the past 30 days** from intake to 6 months. From intake to 6 months, **significantly fewer clients experienced stress (83% to 69%), emotional problems (76% to 63%), and reduced or gave up activities (63% to 52%) due to alcohol or other drug use in the past 30 days**. Clients reported significant reduction in the degree to which they were bothered by psychological problems from intake (90%) to 6 months (86%).

DEPRESSION AND ANXITY DAYS



*Significant at $p \leq 0.05$. The graphic displays the matched sample for depression (n = 524) and anxiety (n = 526).

ADVERSE EFFECTS DUE TO ALCOHOL AND OTHER DRUG USE

Stress*

83% at intake

69% at 6-month follow-up

183

*Significant at p ≤ 0.05 Ascertained collapsed (extremely, considerably) and not ascertained collapsed (not at all, somewhat). Graphic displays matched sample with past 30 day timeframe.

Emotional problems*

76% at intake

63% at 6-month follow-up

169

*Significant at p ≤ 0.05 Ascertained collapsed (extremely, considerably) and not ascertained collapsed (not at all, somewhat). Graphic displays matched sample with past 30 day timeframe.

Reduce or give up important activities*

63% at intake

52% at 6-month follow-up

166

*Significant at p ≤ 0.05 Ascertained collapsed (extremely, considerably) and not ascertained collapsed (not at all, somewhat). Graphic displays matched sample with past 30-day timeframe.

SOCIAL CONNECTEDNESS

Intake

At intake, 37% of clients voluntarily attended a non-religious self-help group; 14% attended a faith based or religious self-help group. **The majority (85%) of clients reported having interactions with family and or friends** who are supportive of their recovery at intake. When asked who the client turns to when having trouble, **family members were the most common support (50%)**, followed by friends (24%), other support (12%), and clergy (1%). Twelve percent of clients reported having no one to turn to when in trouble.

Changes from Intake to 6 Months

The percent of clients who voluntarily attended a non-religious self-help group did not significantly change (43% at intake and 45% at 6 months), while the percent of clients who attended a faith based or religious self-help group marginally decreased from intake (16%) to 6 months (12%). The percent of clients who reported having supportive interactions with family and or friends in the past 30 days remained high from intake (88%) to 6 months (90%) but did not significantly change. Finally, no significant changes were detected for who clients turn to when having trouble.

SUPPORT FOR CLIENTS

Who clients turn to when having trouble

Intake (*n* = 1,814)	Matched Intake (*n* = 530)	Matched 6 Months (*n* = 530)
▸ Family: 50%	▸ Family: 50%	▸ Family: 50%
▸ Friends: 24%	▸ Friends: 27%	▸ Friends: 29%
▸ Other: 14%	▸ Other: 14%	▸ Other: 15%
▸ No one: 12%	▸ No one: 8%	▸ No one: 6%
▸ Clergy: 1%	▸ Clergy: 0%	▸ Clergy: 0%

CONCLUSIONS

In the second year of SOR-2 implementation (October 1, 2021, to September 30, 2022), 51 subgrantees across Oregon provided treatment and recovery services to people with opioid use disorder. A total of 1,885 clients at intake and 561 clients at 6-month follow-up provided GPRA data.

Intake

Responses to **intake GPRA interviews** indicated that 27% of clients reported illicit opioid drug use in the past 30 days, with heroin being the most used opiate. The majority (77%) of clients reported being housed. However, 59% of clients were dissatisfied with their living conditions. Employment at intake was low, with 34% having part-time or full-time employment. Alcohol or substance abuse treatment was the most common form of treatment that clients received in the past 30 days for inpatient (17%) and outpatient (46%) treatment settings. The majority (83%) of clients at intake had been tested for HIV and of those clients, 96% knew their results. Clients reported experiencing severe depression on an average of 9.4 days and anxiety on an average of 13.4 days during the past 30 days.

Changes from Intake to 6 Months

For clients with available **6-month follow-up** interview data, clients reported significant progress decreasing their use of alcohol (2.9 to 1.3 days), illegal drugs (10.1 to 5.7 days), heroin (4.0 to 1.0), and OxyContin/Oxycodone (0.6 to 0.1 days). From intake to 6 months, clients had higher rates of employment (38% to 60%). Significantly fewer clients were on parole or probation (25% to 23%) and awaiting charges, trial, or sentencing (15% to 9%). Clients also reported a significant decrease in the number of days experiencing severe depression (8.8 to 6.7 days) and anxiety (13.9 to 10.4 days). Finally, significantly fewer clients experienced stress (83% to 69%), emotional problems (76% to 63%), and gave up activities (63% to 52%) due to alcohol or other drug use.

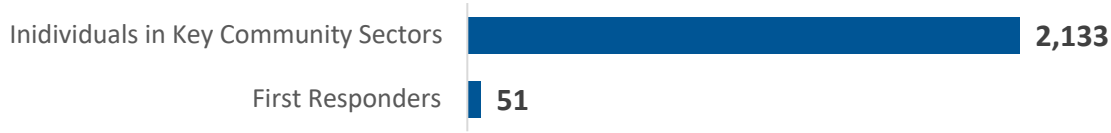
SOR2 | NALOXONE PROGRESS REPORT

Reporting Period: September 2020 – October 2022

Naloxone Purchased, Distributed, and Overdose Reversals

2,724 Overdose Reversals^

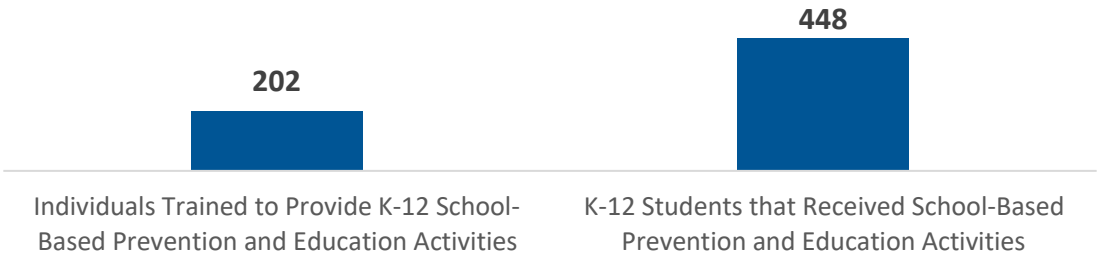
Individuals Trained on Recognizing Opioid Overdoses and Naloxone Use*



Individuals Educated on the Consequences of Opioid Use*

Number of Individuals Educated:

School-Based Opioid Prevention and Education Efforts*



^Overdose reversals are reported only if collected at Naloxone distribution or refill

*Questions were added to the SOR Program Instrument starting in Fiscal Year 2022 Quarter 3.

EVALUATION METHODS

OVERVIEW

This outcome evaluation presents findings from Government Performance and Results Act (GPRA) interview data collected by SOR2 PRIME+ subgrantees. This report describes data collected and processed between October 1, 2020, and September 30, 2022. Clients are asked to take part in the GPRA interview at intake into the SOR-funded program, 6 months after intake, and at discharge.

PARTICIPANTS AND DATA COLLECTION

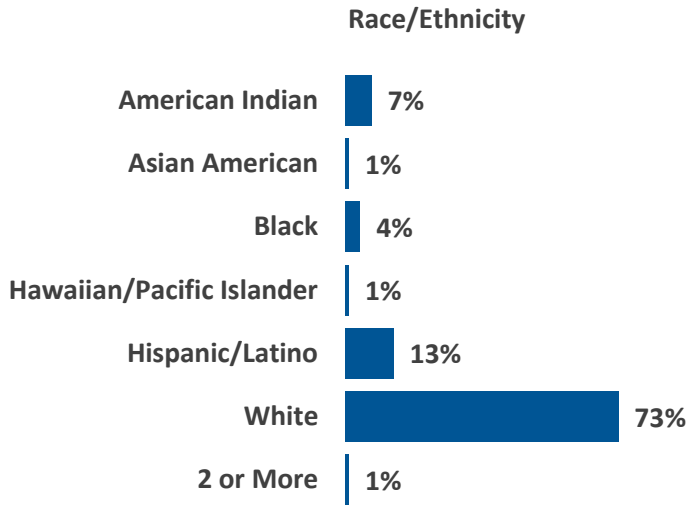
As of September 30, 2022, 879 clients completed GPRA intake interviews. Of those, 873 (99%) signed a consent form to participate in RMC Research's evaluation. A total of 283 clients completed a 6-month GPRA interview. However, 1% (9 of 283) of these interviews were conducted prior to or after the SAMHSA specific follow-up window and are excluded from this report.

ANALYSIS

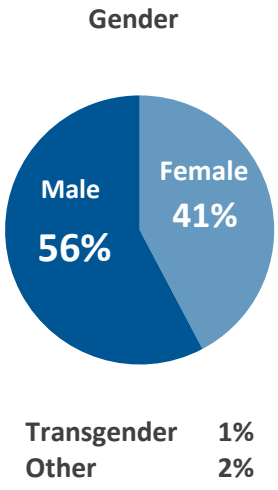
This report describes the **full SOR sample at intake (n=873)** and summarizes the **changes in indicators from intake to 6-month follow-up (n=274)** to answer the evaluation questions related to client progress. Analysis of changes in indicators from intake to 6-months is restricted to clients who completed the intake interview and the 6-month GPRA interview within the SAMHSA specific follow-up window. Clients can refuse to answer questions in the GPRA interview or indicate that they do not know the answer. For each indicator, *refused* and *don't know* were recoded as missing and not included in analyses, thus sample sizes vary. The following table presents indicators included in this evaluation report and analysis methods.

DEMOGRAPHICS

RACE/ETHNICITY AND GENDER

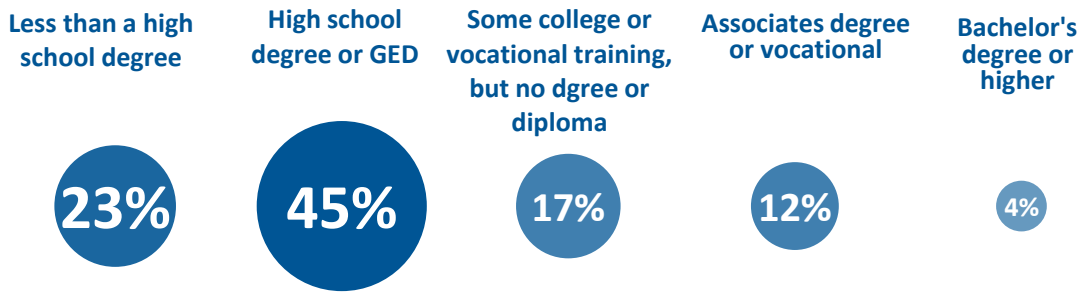


804-846



852

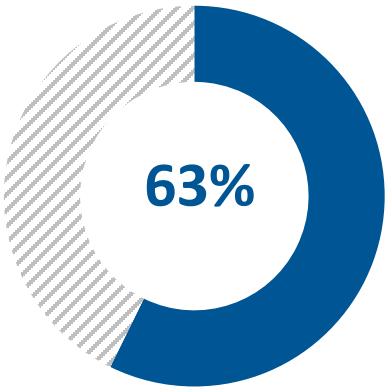
EDUCATION LEVEL



857

CHILDREN AND PREGANCY STATUS

- A small minority (4%) of female or transgender clients are pregnant (sample size, n=384)



of clients have children

845

Number of Children

2.4 average number of children

Parental Rights

27% of clients have lost parental rights

Court Order

21% of clients have children living with someone else due to a court order

Sample sizes: Average number of children (*n* = xx), parental rights (*n* = 354), court order (*n* = 505).

ALCOHOL AND SUBSTANCE USE

PAST 30-DAY OPIOID USE

- Clients demonstrated a significant decline in past 30-day opioid use from intake (20%) to 6 months (13%) (sample size, n=274).
- Clients demonstrated a significant decline in past 30-day drug injection from intake (37%) to 6 months (25%) (sample size, n=182).

AVERAGE PAST 30-DAY USE AMONG ALL CLIENTS

	Entire intake sample	Changes from intake to 6 months (matched)	
Past 30 Day Drug and Alcohol Use	**Intake (*n* = 211-843)**	**Intake (*n* = 230-256)**	**6 Month (*n* = 230-256)**
Alcohol*	**4.5**	**4.7**	**2.7**
Illegal drugs*	**11.2**	**11.5**	**9.1**
Alcohol and drugs on same day	**7.8**	**--**	**--**
Opiates			
Heroin*	**3.8**	**3.9**	**2.3**
OxyContin/Oxycodone	**0.3**	**0.3**	**0.0**
Methamphetamine*	**5.6**	**7.1**	**6.0**
Marijuana/Hashish*	**4.9**	**4.7**	**3.3**
Benzodiazepines	**0.4**	**0.6**	**0.1**
Cocaine/Crack*	**0.3**	**0.2**	**0.0**
Other illegal drugs	**0.7**	**0.4**	**0.4**

*Significant at $p \leq 0.05$. Illicit drugs with an average less than or equal to 0.1 days at intake are excluded from the table and include: Tylenol 2, 3, 4, Percocet, Codeine, Non-prescription methadone, Morphine, Dilaudid, Darvon, Demerol, Non-prescription GHB, hallucinogens, Ketamine, other tranquilizers, and Inhalants. Blank cells are due to low sample size, predominately due to appropriate skip patterns.

LIVING CONDITIONS

LIVING CONDITIONS

	Entire intake sample	Changes from intake to 6 months (matched)	
Past 30-Day Living Conditions	**Intake (*n* = 550-869)**	**Intake (*n* = 153-269)**	**6 Month (*n* = 153-269)**
Place of residence			
Housed*	63%	64%	71%
Own/rent apartment	42%	54%	54%
Someone else's apartment	26%	21%	21%
Residential treatment	11%	7%	7%
Halfway house	6%	9%	9%
Other	15%	10%	10%
Shelter	10%	10%	7%
Street/outdoors	22%	21%	19%
Institution	6%	5%	4%
Satisfaction with living conditions			
Very dissatisfied	14%	19%	22%
Dissatisfied	32%	31%	31%
Neither dissatisfied nor satisfied	14%	16%	16%
Satisfied	17%	12%	8%
Very satisfied	22%	22%	23%

*Significant at $p \leq 0.05$. Percentages may not add up to 100% due to rounding. Cell sample sizes were too small for categorical analysis and thus Likert scale treated as a numeric value.

EMPLOYMENT AND INCOME

EMPLOYMENT STATUS AND PERCEPTION OF INCOME

Employed*

29% at intake

50% at 6-month follow-up

190

*Significant at $p \leq 0.05$. Disabled, other, and retired were exluded. Graphic displays matched sample. Employment in full intake sample was 23% (sample size, n=823).

Enough Money to Meet Needs*

23% at intake

32% at 6-month follow-up

262

*Significant at $p \leq 0.05$ Ascertained collapsed (completely, mostly, moderately) and not ascertained collapsed (a little, not at all). Graphic displays matched sample. Full intake sample 21% ascertained (sample size, n=848).

Enrollment in a school or job training program

Intake (*n* = 857)	Matched Intake (*n* = 264)	Matched 6 Months (*n* = 264)
▸ Not enrolled: 96%	▸ Not enrolled: 93%	▸ Not enrolled: 97%
▸ Full time: 2%	▸ Full time: 2%	▸ Full time: 2%
▸ Part time: 1%	▸ Part time: 5%	▸ Part time: 1%
▸ Other: 1%	▸ Other: 0%	▸ Other: 0%

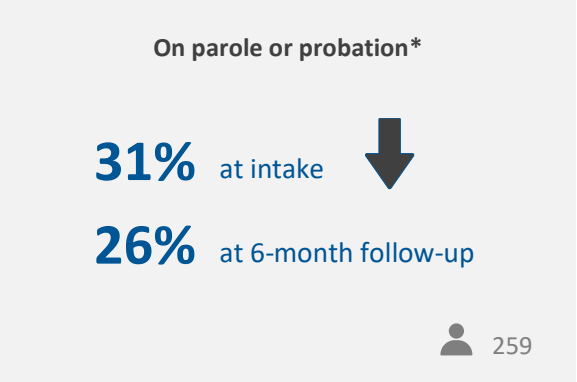
CRIME AND CRIMINAL JUSTICE

CRIME AND CRIMINAL JUSTICE

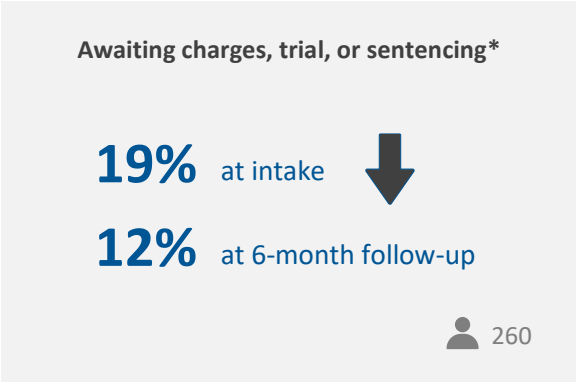
	Entire intake sample	Changes from intake to 6 months (matched)	
Past 30-Day Crime and Criminal Justice	**Intake (*n* = 90-851)**	**Intake (*n* = xx-xx)**	**6 Month (*n* = 264-268)**
Arrested	**0.1**	**0.1**	**0.2**
Arrested for drug-related offense	**0.4**	**--**	**--**
Nights spent in jail/prison	**1.5**	**1.2**	**1.0**

Cells present average number of times in the past 30-day period. Blank cells are due to low sample size, predominately due to appropriate skip patterns.

CORRECTIONS



*Significant at $p \leq 0.05$. In the full intake sample (n = 846), 30% of were on parole of probation. Graphic displays matched sample.



*Significant at $p \leq 0.05$. In the full intake sample (n = 845), 19% of clients were awaiting charges, trial, or sentencing. Graphic displays matched sample.

PHYSICAL HEALTH

TREATMENT

	Entire intake sample	Changes from intake to 6 months (matched)	
Past 30 Reception of Treatment	**Intake (*n* = 841-850)**	**Intake (*n* = 250-263)**	**6 Month (*n* = 250-263)**
Inpatient treatment			
Physical complaint	7%	6%	2%
Mental or emotional difficulties	7%	6%	2%
Alcohol or substance use*	14%	17%	5%
Outpatient treatment			
Physical complaint*	12%	12%	10%
Mental or emotional difficulties*	15%	17%	15%
Alcohol or substance use*	27%	28%	29%
Emergency room treatment			
Physical complaint	19%	21%	16%
Mental or emotional difficulties*	8%	9%	2%
Alcohol or substance use*	13%	14%	3%

*Significant at $p \leq 0.05$. Percentages may not add up to 100% due to rounding.

HIV TESTING

	Entire intake sample	Changes from intake to 6 months (matched)	
HIV Testing	**Intake (*n* = 685-818)**	**Intake (*n* = 208-254)**	**6 Month (*n* = 208-254)**
Ever tested*	84%	86%	92%
Know the results of the test	93%	95%	97%

*Significant at $p \leq 0.05$.

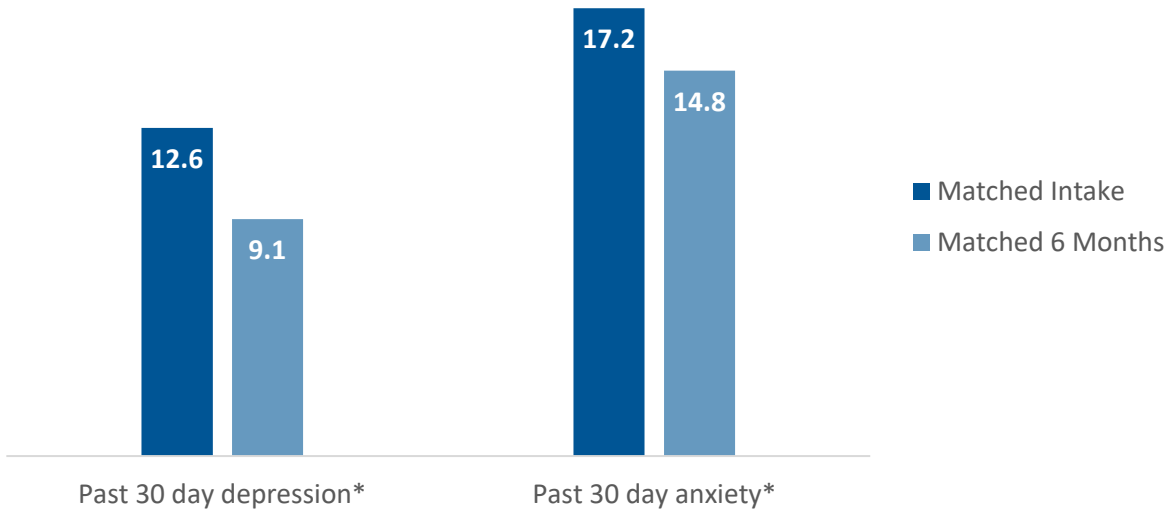
HEALTH RATING AND QUALITY OF LIFE

	Entire intake sample	Changes from intake to 6 months (matched)	
Health and Quality of Life	**Intake (*n* = 836-850)**	**Intake (*n* = 256-263)**	**6 Month (*n* = 256-263)**
Health rating*			
Poor	21%	19%	11%
Fair	32%	31%	26%
Good	31%	29%	37%
Very good	12%	15%	18%
Excellent	5%	6%	9%
Satisfaction with health*			
Very dissatisfied	8%	10%	12%
Dissatisfied	35%	36%	42%
Neither satisfied nor dissatisfied	23%	20%	24%
Satisfied	22%	20%	14%
Very satisfied	12%	14%	8%
Ability to perform daily activities*			
Very dissatisfied	14%	15%	26%
Dissatisfied	37%	36%	40%
Neither satisfied nor dissatisfied	18%	17%	15%
Satisfied	23%	21%	12%
Very satisfied	10%	10%	7%
Enough energy for everyday life*			
Not at all	20%	20%	12%
A little	18%	19%	16%
Moderately	22%	18%	16%
Mostly	26%	27%	31%
Completely	15%	16%	25%
Quality of life*			
Very poor	8%	9%	6%
Poor	17%	15%	10%
Neither poor nor good	27%	23%	21%
Good	35%	40%	42%
Very good	12%	13%	21%

*Significant at $p \leq 0.05$. Percentages may not add up to 100% due to rounding. Cell sample sizes were too small for categorical analysis and thus Likert scale treated as a numeric value.

MENTAL HEALTH AND ADVERSE EFFECTS

DEPRESSION AND ANXITY DAYS



*Significant at $p \leq 0.05$. In the full intake sample, clients reported experiencing depression and anxienty on an average of 12.0 (n = 798) and 16.4 (n = 824) days, respectively. The graphic displays the matched sample for depression (n = 252) and anxiety (n = 258).

ADVERSE EFFECTS DUE TO ALCOHOL AND OTHER DRUG USE

Stress*

82% at intake

67% at 6-month follow-up

129

*Significant at p ≤ 0.05 Ascertained collapsed (extremely, considerably) and not ascertained collapsed (not at all, somewhat). Graphic displays matched sample with past 30 day timeframe. In the full intake sample (*n* = 629), 82% experienced stress.

Emotional problems*

74% at intake

60% at 6-month follow-up

123

*Significant at p ≤ 0.05 Ascertained collapsed (extremely, considerably) and not ascertained collapsed (not at all, somewhat). Graphic displays matched sample with past 30 day timeframe. In the full intake sample (*n* = 612), 78% experienced emotional problems.

Reduce or give up important activities*

62% at intake

43% at 6-month follow-up

118

*Significant at p ≤ 0.05 Ascertained collapsed (extremely, considerably) and not ascertained collapsed (not at all, somewhat). Graphic displays matched sample with past 30-day timeframe. In the full intake sample (*n* = 591), 69% reported reducing or giving up important activities.

SOCIAL CONNECTEDNESS

SELF HELP GROUPS AND SUPPORT

	Entire intake sample	Changes from intake to 6 months (matched)	
Past 30-Day Support	**Intake (*n* = 846-851)**	**Intake (*n* = 260-263)**	**6 Month (*n* = 260-263)**
Attends non-religious group*	**36%**	**38%**	**45%**
Attends faith-based group	**15%**	**12%**	**15%**
Has had supportive interactions	**79%**	**85%**	**87%**

*Significant at $p \leq 0.05$.

SUPPORT FOR CLIENTS

Who clients turn to when having trouble

Intake (*n* = 822)	Matched Intake (*n* = 255)	Matched 6 Months (*n* = 255)
▸ Family: 38%	▸ Family: 43%	▸ Family: 41%
▸ Friends: 24%	▸ Friends: 28%	▸ Friends: 29%
▸ Other: 16%	▸ Other: 15%	▸ Other: 19%
▸ No one: 16%	▸ No one: 13%	▸ No one: 9%
▸ Clergy: 1%	▸ Clergy: 1%	▸ Clergy: 0%

Appendix C. State Opioid Response Grant 2: Medication Assisted Treatment Expansion Evaluation

November 2022

State Opioid Response 2 Grant:

Medication Assisted Treatment Expansion Evaluation

Authors (alphabetical):
Christine Cooper
Carrie Furrer
Yumi Lee

Portland State UNIVERSITY

Oregon Health Authority

Contents

Acknowledgement

We would like to thank the program staff who work each day to provide life-saving MAT services. We appreciate the time you spent sharing your experiences with us for this evaluation.

Portland State University Contact:
Yumi Lee
yumi.lee@pdx.edu

Oregon Health Authority Contact:
Kelsey Smith-Payne
kelsey.smithpayne@dhsoha.state.or.us

Background

The Substance Abuse and Mental Health Services Administration (SAMHSA) funded a fiscal year (FY) 2020 cohort of the State Opioid Response grant program (referred to here as SOR2). The purpose of SOR2 was to address the opioid crisis by providing resources for increasing access to FDA-approved medications for the treatment of opioid use disorders (OUD) and to help reduce unmet treatment needs and opioid-related overdose deaths across the United States.

In 2020, 91,799 overdose deaths occurred in the United States and 74.8% were opioid-related,[1] Underscoring the need for OUD treatment approaches that can improve patient survival and support sustained recovery. Medication-assisted treatment (MAT) is an evidence-based approach to treating OUD by providing a controlled level of naltrexone, buprenorphine, or methadone to relieve withdrawal symptoms.[2]

The Oregon Health Authority (OHA) contracted with Portland State University (PSU) to conduct an impact evaluation of SOR2 funding. As part of the evaluation, PSU conducted a sub-study (referred to as the "MAT evaluation") focused on MAT program implementation, and whether SOR2 funding expanded access to and utilization of MAT services in Oregon. PSU aligned the MAT evaluation with OHA's definition of health equity:

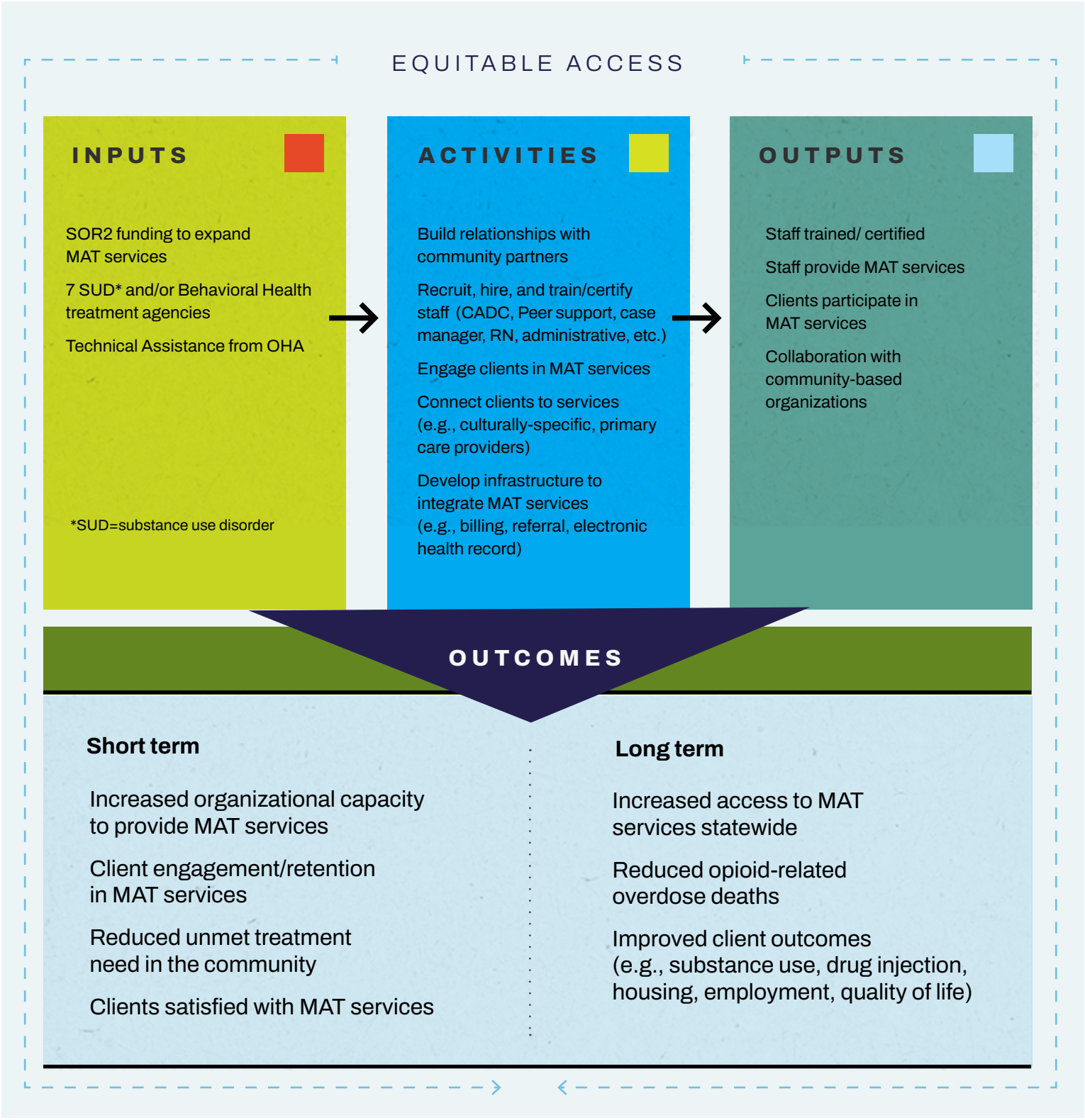
> *"a health system that creates health equity when all people can reach their full health potential and well-being and are not disadvantaged by their race, ethnicity, language, disability, age, gender, gender identity, sexual orientation, social class, intersections among these communities or identities, or other socially determined circumstance."* [3]

Disinvested and marginalized communities are disproportionately affected by the effects of OUD.[4,5] As such, the MAT evaluation sought to examine the equitable distribution of resources, including culturally-specific and -responsive services; identify systemic barriers to utilization of and access to MAT services and whether these barriers placed specific groups at a disadvantage; and to implicate the system as perpetuating the root causes of health inequities.

PSU developed a logic model to frame the evaluation (see Figure 1).
The questions guiding this MAT evaluation were:

1. How were MAT services implemented and what were the challenges (Activities and Outputs)?
2. Did SOR2 funding increase access to MAT services in Oregon (Short-term Outcomes)?
3. To what extent did people with OUD use and benefit from SOR2-funded MAT services (Long-term Outcomes)?

Figure 1.
Logic Model



Description of SOR2-funded Agencies Providing MAT Services

Seven agencies were included in this evaluation, most newly providing MAT or expanding MAT in new locations. As such, most locations had been providing MAT services for less than two years. Six agencies were office-based opioid treatment (OBOT) programs, which allow primary care or general care providers with an X waiver (created by the Drug Addiction Treatment Act, or DATA) to prescribe MAT medications (e.g., buprenorphine, buprenorphine/naloxone, naltrexone).[6]

One agency was an opioid treatment program (OTP). OTPs integrate substance use disorder (SUD) treatment with various recovery support services and are certified to dispense methadone as well as buprenorphine.[7] Additionally, three of the OBOTs were primarily behavioral health clinics – two provided some degree of primary care access in addition to behavioral health services, and one was an OBOT-only located on a hospital campus.

Most of these agencies adopted a MAT-first model, where clients receive medication as quickly as possible prior to lengthy assessments. Two agencies were bridge clinics, providing short-term services to increase speed of access to medications and then working to connect clients with long-term access. The MAT-first model is consistent with SAMHSA's treatment guidelines that emphasizes the need to get clients into treatment as soon as possible and for as long as it is beneficial.[8]

Agencies were located in a mix of rural and urban settings. Most agencies saw a need to implement or expand MAT services in their communities due to growing numbers of opioid-related overdose deaths, a lack of services in the community, and/or to provide follow-up support for individuals on probation and emergency department (ED) admissions due to overdoses.

Although agencies worked with all community members, they also reported providing additional supports for one or more of the following priority populations: monolingual Spanish speakers/non-English speakers, Latine/Hispanic,* Native American, unhoused, low income, incarcerated or parolees, LGBTQIA2S+, and rural/frontier. Other equity-focused efforts included using culturally-responsive tools, practices, and services (e.g., interpreters, translated materials), and/or connecting clients to culturally-specific programs. Most agencies also reported a diverse staff and/or had the goal of further diversifying staff.

MAT Grantee Characteristics

- 6 OBOT, 1 OTP
- Most adopted MAT-first model
- 2 bridge clinics
- Mix of rural & urban settings
- Goals related to serving priority populations

*In this report we use the term "Latine" as a gender-neutral alternative to "Latino" that is more natural to pronounce when communicating in Spanish. We use the term "Hispanic" to refer to people who speak Spanish.

Methods

The MAT evaluation included three primary data sources: grantee interviews, SOR2 grantee progress reports, and GPRA (Government Performance and Results Act) client outcome interviews. In this section, we describe the procedures for data collection and analysis for each data source.

Grantee Interviews

PSU conducted interviews with key staff at each grantee agency to gather information on how MAT services were implemented and the challenges agencies faced.

Data Collection

Data collection took place between June 2021 and July 2022. In consultation with OHA, PSU identified the MAT expansion agencies and their key staff (e.g., supervisors, project coordinators, prescribers, CEOs, directors, program leaders). OHA compiled contact information for the key staff and PSU invited them to participate in an interview.

PSU conducted two rounds of interviews. For the first round, PSU worked with OHA to develop a semi-structured interview protocol that focused on the MAT grantees' implementation successes and barriers, approach to health equity, and collaboration efforts (see Appendix A for the interview questions).

Before starting the interview, PSU reviewed an informed consent form with participants and received verbal consent. Interviews were conducted using a video conferencing platform and audio recorded for transcription. Interviews lasted 60 minutes for each agency, with the exception of one agency that included an additional 30-minute interview to learn more about their Diversity, Equity, and Inclusion (DEI) initiative from the person leading it. A total of ten key staff from seven agencies participated in the first round of interviews.

For the second round of interviews, PSU followed up with key staff from the first round. PSU again worked with the OHA team to create a semi-structured interview protocol, which was also informed by preliminary findings from the first round of interviews. Round two interviews facilitated open-ended conversations about MAT grantees' implementation supports and program changes, their approach to addressing barriers to health equity, and handling misconceptions about MAT (see Appendix B for the interview questions). Interviews lasted 60 minutes and procedures were the same as those described for the first round of interviews. Nine key staff from seven agencies participated in the second round of interviews.

Coding and Analysis

Recordings for both rounds of interviews were professionally transcribed before analysis. All interview transcripts were de-identified and Atlas.ti was used for data management and analysis. Interviews were coded in two cycles. In the first cycle, data were coded deductively using a framework created by the PSU team to broadly capture topics covered in the interview questions, such as implementation successes and challenges, supports, collaborations, plans to support health equity, and approaches in handling misconceptions about MAT. After sorting the data into broad categories, the second cycle consisted of capturing additional themes that emerged by open-coding a subsample of the data.

SOR2 Grantee Progress Reports

PSU used information from each grantee's set of bi-annual progress reports to evaluate the impact of SOR2 funding on expanding access to MAT services in Oregon.

Data Collection

Grantees were required to complete progress reports every six months of the two-year SOR2 funding period. For this evaluation, PSU reviewed each grantee's Year 1 mid-year, Year 1 end-of-year, and Year 2 mid-year progress reports (as available). We focused on two SAMHSA-required questions included on all three progress reports:

- How many unduplicated clients received treatment services for OUD?
  Received methadone?
  Received Buprenorphine?
  Received Naltrexone?

- Describe your major accomplishments related to your SOR2-funded activities during the report period.

Coding and Analysis

PSU developed a data extraction tool to organize progress report information for each grantee over time. First, we reviewed the goals that each grantee copied into their progress report from their contract or scope of work. For this analysis, we focused on goals related to expanding the availability of MAT services. Second, we reviewed each progress report and extracted any information pertaining to each goal, thereby "tracking" progress made over time (Year 1 mid-year, Year 1 end-of-year, and Year 2 mid-year). We also looked for evidence of equitable access to MAT services (e.g., disaggregated client numbers) and/or descriptions of efforts made to ensure equitable access for priority populations. Analysis involved identifying patterns across grantees in terms of progress made on similar goals (outcomes). We also compiled the OUD treatment numbers that grantees logged in their progress reports as another indicator of the availability of MAT services.

Government Performance and Results Act Client Outcome Measurement Tool

The Government Performance and Results Act (GPRA) requires all Federal departments and agencies to develop strategic plans and annually report their progress toward meeting their identified goals. Agencies are expected to regularly conduct evaluations of their programs and to use the results of those evaluations to explain their successes and failures based on the performance monitoring data. SAMHSA's data strategy includes the use of "National Outcome Measures" for measuring how effective the implementation of substance abuse treatment services is in communities across the nation.

SOR2 grantees providing treatment and recovery services were required to use the US Center for Substance Abuse Treatment (CSAT) GPRA Client Outcome Measures for Discretionary Programs Tool to collect outcome data from their clients at the time of intake and six months after intake (6-month follow-up). The GPRA interview included questions about demographic information, treatment, trauma, and substance use during the past 30 days.RMC Research oversaw GRPA data collection for the SOR2 grantees, and grantee staff conducted the interviews with clients. Because PSU did not have access to client-level GPRA data, we worked with RMC Research to develop an analysis plan to assess the degree to which clients utilized and benefitted from SOR2-funded MAT services.

Data Analysis

RMC Research used SPSS to analyze GPRA data for clients receiving services from the seven MAT agencies included in this evaluation. Analysis included descriptive statistics (frequencies, means) at intake and the 6-month follow-up, as well as statistical tests of change (McNemar tests and paired t-tests) over time for clients with data at both time points (referred to as the "6-month follow-up sample") for GPRA variables related to past 30-day drug use, harm reduction practices, quality of life, employment, satisfaction, and demographics. PSU met with RMC Research and OHA partners to discuss and make meaning from the results.

Description of MAT Clients at Intake

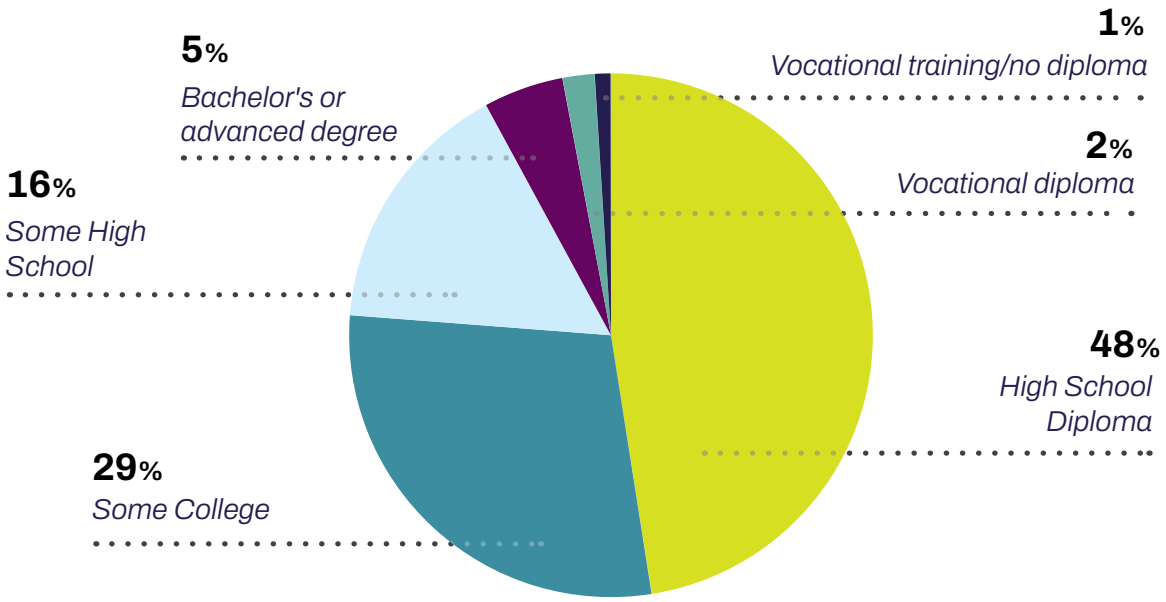
The GPRA client outcome interview was administered to 1,048 MAT clients between October 1, 2020 and June 30, 2022. Demographic data were available for the intake sample only, so the following is meant to provide a general description of the MAT clients who completed a GRPA interview.

Educational attainment

Almost half of MAT clients (Figure 2) who provided information about their education (n=1,034) earned their high school diploma or equivalent (48%, n=493). Most of the remaining clients had some type of post-secondary education: 29% (n=296) completed some college; 5% (n=47) earned a bachelor's or other advanced degree; 2% (n=19) attained a vocational diploma after high school; and 1% (n=10) attended vocational training but did not earn a diploma. Sixteen percent (n=169) of the clients completed some high school.

Figure 2

Education level at intake



Gender

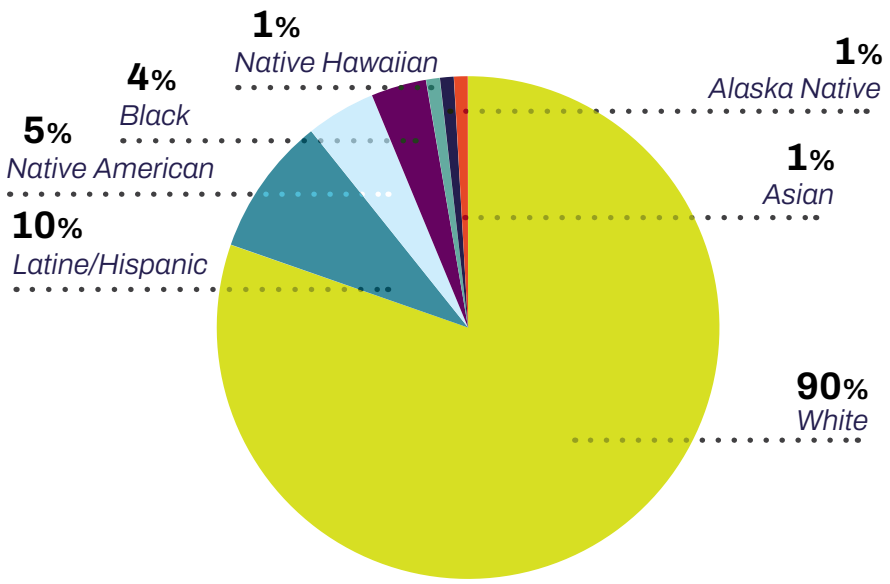
A larger share of MAT clients identified as male (59%, n=623) than female (40%, n=421), and a small proportion identified as transgender or another gender (n<5).

Race/Ethnicity

As shown in Figure 3, one in 10 MAT clients identified as Latine/Hispanic, Native American, Black, Alaska Native, Native Hawaiian, and/or Asian (participants could select more than one category). Nine in 10 MAT clients identified as white (a small number identified as white and another race). Of those who identified as Latine/Hispanic, half indicated they were Mexican.

Figure 3

MAT client race/ethnicity at intake



Note: Clients could select more than one category. View reference data in Table 1.

Results

The MAT evaluation results are organized in three sections according to the evaluation questions:

1. How were MAT services implemented and what were the challenges?
2. Did SOR2 funding increase access to MAT services in Oregon?
3. To what extent did people with OUD use and benefit from SOR2-funded MAT services?

1. How were MAT services implemented and what were the challenges?

Although research has shown that MAT is a clinically effective approach to treating OUD, it can be challenging to implement in routine healthcare settings without key organizational supports in place. The SOR2 MAT evaluation focused on understanding how grantees implemented MAT services in their organizations, the factors that facilitated the adoption of MAT, and the challenges they faced. Grantees were also asked to share lessons learned and recommendations for other organizations implementing MAT.

Using an Implementation Science Framework

PSU used the National Implementation Research Network (NIRN) framework as a guide.[9] Two concepts, implementation drivers and stages of implementation, were particularly useful for organizing the findings.

Implementation drivers are key supports needed for the successful uptake of a program or intervention. The most relevant drivers for this analysis included:

- Systems intervention
  (e.g., community alignment, integrating with other systems)
- Facilitative administration
  (e.g., organizational infrastructure to support the program)
- Data systems that support decision making
  and continuous improvement
- Staff hiring and training

Stages of implementation are phases of activity needed to put the program or intervention in place. The stages are:

- Exploration: initial decision making, defining the program
- Installation: developing teams, training, systems
- Initial implementation: staff start using the program with clients
- Full implementation: expand intervention, continuous improvement

MAT Implementation Findings

In this section, we describe how grantees implemented MAT services in terms of

1. early planning and infrastructure development,
2. service integration, and
3. workforce development.

1 Early Planning and Infrastructure Development

Implementation research points to the importance of planning and developing infrastructure prior to integrating changes in an organization.[10,11] Fixsen and colleagues define implementation as "a specified set of activities designed to put into practice an activity or program".[12] Implementation is not an event but "activities occur[ing] over time in stages that overlap and that are revisited as needed."[13] All MAT grantees described some level of planning and adaptation that began prior to initiating MAT services.

The following is a description of the grantees' early implementation activities that are characteristic of NIRN's exploration and installation stages of implementation organized by four key themes:

- Ongoing communication with diverse, knowledgeable informants
- Collaboration with other system providers
- Addressing organizational and community buy-in
- Determining economic feasibility and sustainability planning

Impact of Covid-19 Pandemic

It is important to address the significant impact that the COVID-19 pandemic had on MAT implementation and service delivery. Most notably, grantees had to revamp protocols to accommodate COVID-19 screening and social distancing rules, including providing buprenorphine prescriptions for a longer duration and requiring fewer urine screenings. Grantees also identified other impacts:

- The expedited and expanded use of telehealth services.
- Staffing issues, which included managing illness and turnover as well as challenges hiring enough staff to fully implement MAT programs.
- The strain on partner organizations (and closure of some) increased demands placed on grantees. For example, short-term bridge clinics were forced to maintain clients for longer periods than expected.
- Strain on time and resources, and social distancing rules, limited capacity to build and sustain collaborative partnerships with other organizations, such as jails and EDs.
- Supply chain issues impacted access to supplies such as Librium, used for treating alcohol withdrawal.

ONGOING COMMUNICATION WITH DIVERSE, KNOWLEDGEABLE INFORMANTS

The NIRN framework emphasizes the importance of communication with key people, such as "practitioners, administrators, and other staff members, families and community stakeholders, purveyors and 'experts' and with other implementing sites and local entities"[14] in the exploration stage of implementation. Grantee planning efforts involved committees made up of key agency staff such as financial advisors and operations managers, as well as local culturally-specific organizations and other knowledgeable community partners. At least one agency included input from a peer.

> *"Peers" are individuals with lived experience with SUD who are part of the SUD workforce. Some members of the peer workforce are credentialed (Peer Support Specialist [PSS], Peer Wellness Specialist [PWS], Certified Recovery Mentors [CRM]).*

Despite these efforts, grantees noted a lack of diverse voices in MAT planning, in part influenced by the lack of time and resources available for planning at the start of a 2-year grant cycle. Indeed, several grantees said they were hiring key staff and developing program protocols months after grant funding began.

When planning for MAT services, some key grantee recommendations included:

Connect with expert consultants. Grantees stressed the importance of guidance and planning support from expert consultants. OHA provided guidance but some grantees needed more support. One agency described spending a large sum of money on early support from a consulting agency that didn't adequately prepare them for providing MAT services. Early connections to known experts such as the Opioid Response Network would have been helpful.

Connect with other organizations providing MAT. Overwhelmingly, grantees described the importance of connecting with, and even touring facilities of, other MAT agencies. Some grantees said they reached out to other OBOTs, but nearly all agencies wanted help coordinating opportunities to regularly meet with "non-threatening," fellow OBOTs for sharing lessons learned and brainstorming issues.

Include key agency staff in early implementation. Grantees identified key staff needed to support the implementation of MAT services: administrative and operations staff for scheduling and triaging; care coordinators; prescribers; clinical supervisors for behavioral health staff; and, importantly, internal champions of MAT to help increase staff buy-in and to maintain momentum (see Addressing organizational and community buy-in for more information).

Strategize to promote equitable access and service delivery from the beginning. Many grantees shared they have non-discrimination service delivery policies; however, several agencies described having specific strategies to promote equity. For example, one grantee implemented a DEI initiative at their agency. Another grantee explained that their umbrella agency has a monthly meeting that includes staff from each location coming together to discuss ways they can better support their clients, which resulted in updated forms that are more gender inclusive.

COLLABORATION WITH OTHER SYSTEM PROVIDERS

According to the NIRN framework, *systems intervention* is an implementation driver necessary to support and sustain a program or intervention by working with external partners to secure resources, and identify and remove systemic barriers to service delivery.[15]

Grantees shared some examples of their systems intervention work, including reasons for building relationships with external partners:

Created pathways for streamlining referrals and continuous service provision. With a goal of increasing services to the Latine/Hispanic community, one agency partnered with a local health clinic focused on serving this population to set up referral and transfer pathways. Another agency partnered with an organization that worked with the Black/African American community to provide MAT services at their location. Additionally, several grantees described networking and setting up pathways to MAT services with jails and community corrections (e.g., transition centers and probation officers), housing services and shelters, and EDs. As a bridge clinic, one grantee created formal protocols for connecting clients to long-term MAT providers.

Collaborated with insurance providers to address reimbursement and prescribing challenges. Several grantees collaborated with Coordinated Care Organizations (CCOs) to set up medical processes that met reimbursement requirements (e.g., staff credentials). Grantees also experienced challenges with CCOs denying prescriptions for clients. Grantees recommended collaborating early to ensure agency policies and protocols meet insurance requirements to avoid non-reimbursements (see Economic feasibility and sustainability planning for more information on billing and reimbursements).

ADDRESSING ORGANIZATIONAL AND COMMUNITY BUY-IN

The NIRN framework points to the importance of assessing staff readiness for change and of having a designated team to support the integration of a program throughout implementation.[16] Several grantees noted this as well, with many stressing the importance of getting staff buy-in early and in an ongoing manner. Grantees also described ways they supported buy-in from the community and clients who may have questions or misconceptions about MAT.

Traditional abstinence-based approaches to SUD treatment have added to the stigma about MAT.[17] Even though MAT is an evidence-based treatment practice, there are still treatment providers who believe in using MAT only if traditional treatment approaches fail.[18] Some grantees found that staff were not always upfront with their reservations about MAT. One grantee that did not have organizational buy-in for MAT at their agency, reflected that it may have been better to set up their MAT program in parallel to their other SUD services and work to integrate the programs later.

Coordinated Care Organizations, or CCOs, are a regional network of health care providers who serve people who receive health care coverage under the Oregon Health Plan (OHP), i.e., Medicaid.

Grantees recommended taking "a long-term view" when planning to shift organizational culture from being "a drug-free program to an integrated MAT program." To support this shift, grantees offered several suggestions:

Share evidence of client successes.
Agencies educated staff with MAT-focused trainings and by sharing data (both national and their agency's client short-term outcomes) about the effectiveness of MAT in treating OUD. They also communicated about and celebrated their clients' successes to help staff "see" MAT as a legitimate treatment.

Focus on harm reduction.
Agencies trained staff to focus on harm reduction rather than sobriety. As one MAT provider put it, drug use and its associated activities are on a spectrum of harm and any reduction in that harm should be seen "as a win."

Clearly define your organizational mission.
Having a clearly defined mission that ties into the agency's MAT goals was helpful for reducing staff misunderstandings about harm reduction. For example, one grantee described doing a thorough agency review to make sure all their policies and practices aligned with their harm reduction goals.

Have MAT champions and knowledgeable advocates on staff.
Grantees recommended hiring knowledgeable staff that fit the agency culture and planning for ongoing training. Some agencies already had staff champions and expert advocates for MAT. Agency leadership who are proponents of MAT and harm reduction more broadly was also helpful to encourage staff buy-in.

The discrepancies between traditional abstinence-based treatments and MAT can also be difficult for some clients to navigate. Clients often know they are stigmatized and some will start MAT with a focus on weaning off as soon as possible. Agencies described various ways to support clients in overcoming bias toward MAT, including outreach from peers, support groups, and educating them about MAT. In addition, agencies worked to build trust with clients, and made sure their clinicians were up to date on guidelines to prevent them from communicating conflicting information or using stigmatizing language. One grantee also recommended promoting MAT as a wellness model in that clients use MAT to curb their cravings so they can focus on sleep, nutrition, and other recovery needs.

Agencies described outreach efforts to educate various populations in the community, such as translating and distributing MAT materials in Spanish and providing MAT literature to people who are unhoused. Grantees also described using naloxone training for law enforcement and fire departments as an opportunity to educate them about MAT. Additional suggestions for addressing stigma include public education campaigns on the evidence-based outcomes of MAT, meeting with community leaders, and having an open-door policy at the agency for anyone with questions.

> *"[We supported getting community buy-in by having a] public campaign and meeting with the leaders, meeting with their probation officers, meeting with their sheriffs and police departments, just to start an education to help with understanding. That's what we did here early on. We met with them to talk about what MAT was and how it helps with treatment."*

ECONOMIC FEASIBILITY AND SUSTAINABILITY PLANNING

The NIRN framework underscores the significance of financial sustainability, which involves having established and sustainable funding streams for the program.[19] Likewise, most agencies described a need for robust planning around economic feasibility and insurance reimbursement rates. One agency recommended a close examination of local needs and projected utilization rates, especially when looking to provide MAT in rural areas with a larger catchment area and fewer people. In contrast to planning for lower numbers of clients in some rural areas, another grantee shared they didn't ask for enough funding to cover the extraordinary need for MAT services, although some of the need may be attributed to partner agency closures due to the pandemic.

Funding issues for some grantees were compounded by problems they had with getting reimbursed for services, particularly for those agencies that were not set up as medical providers. Three of the seven grantees had embedded OBOT services (which are designated physical health services) within a primarily behavioral health setting. According to grantees, Oregon's CCOs have different rules and policies about how payments are made for behavioral health /SUD and physical health services. In some cases, grantees said they were not reimbursed for services. Some grantees reported working with CCOs to develop processes that both met billing requirements and allowed them to provide rapid access to MAT. For example, one agency described developing a short "biopsychosocial" assessment to administer to MAT clients at intake that met behavioral health policy requirements rather than doing the standard SUD assessment.

Many grantees faced challenges identifying the correct billing codes to use, and they struggled to navigate billing structures and reimbursement policies including:

Ensuring staff credentials met reimbursement policies.
For example, some agencies described the challenge of ensuring the appropriate medical professional was providing services in order to meet requirements for reimbursement (e.g., a RN (Registered Nurse) must provide certain services, whereas other services can be provided by a LPN (Licensed Nurse Practitioner)). Grantees also noted that CCOs can take a long time to credential providers and, in the meantime, agencies cannot bill for the services they provide.

Navigating fee-for-service vs. flat rate per client reimbursements.
Some grantees billed for each service they provided while others received a flat rate for each client. Several grantees described providing primary care services for which they were not reimbursed, either because they could not bill for it or the cost of the services provided exceeded the flat rate. One grantee said they appreciated that a flat rate per client can reduce the complexity of billing and allow for freedom in providing needed services; however, it also puts a cap on the amount the agency receives for treating a given client.

Gaps in insurance coverage.
Grantees said that gaps in insurance coverage (e.g., disruptions in private insurance coverage or when clients become incarcerated) made it challenging for agencies to bill for services.

Navigating rules about the type of primary care their agency can provide.
Some grantees explained that agencies designated as MAT medical providers can only bill for SUD-related services, e.g., the agency can prescribe an antibiotic if a client has an abscess from intravenous (IV) drug use but not if the client is sick with a cold. Furthermore, as licensed medical providers, some MAT grantees said that billing rules can interfere with their relationships with clients who trust them and would prefer to receive primary care in an office where they feel comfortable and experience less stigma around their drug use.

Catchment areas for insurance providers.
MAT services often included unhoused clients who sometimes cross insurance coverage catchment areas as they move for housing or other services. Grantees noted that it can be challenging to get reimbursed for services when a client isn't living in their CCO's catchment area.

Prior authorizations for reimbursements conflict with rapid access to MAT.
Grantees pointed out that the need for prior authorizations from insurance companies is in conflict with providing rapid access services intended to induce clients on medication as soon as they are ready.

Outreach activities are not reimbursable.
Several grantees noted the importance of outreach to clients about available MAT services. Targeted outreach is also a strategy for removing barriers to accessing MAT, which can support equitable access to services. Most grantees focused outreach on the unhoused population but a few also focused on the Latine/Hispanic community. Grantees said it was challenging to conduct outreach activities when they do not have a way to bill or funding for staff time spent doing so.

As previously mentioned, several grantees recommended working out a contract with Medicaid and other insurance providers prior to implementing MAT services. One grantee said they negotiated their contract with the CCO in advance of SOR2 funding. They had no issues with reimbursements and were able to serve clients across counties where there are no MAT providers. This grantee is now negotiating similar contracts with commercial payers. Other suggestions included identifying which clients can be covered by agency general funds when clients do not qualify for OHP, learning from other MAT providers how to navigate billing issues, hiring a billing specialist, and being prepared to encounter issues with billing.

> *"A lot of this level of health care and behavioral health care is about relationship and time spent. That's something that payers have a hard time understanding. It's easy to write a prescription for a pill. It still takes an hour to have that conversation with the client before you can get them started and to completely educate them. A recognition of the importance of the amount of time that's being spent is significant. Having an agreement [with the insurance provider] ahead of time, I think, makes a big difference."*

2 Service Integration

The installation phase of implementation, according to the NIRN framework, includes developing policies, protocols, data tracking systems, and other needed infrastructure that support quality service provision and help identify where improvements can be made.[20] Grantees provided some examples and recommendations for integrating MAT and supporting services in their agencies, including:

- Identifying and building needed infrastructure,
- Efforts to promote continuous quality improvement,
- Integrating peer support services, and
- Adapting MAT services to include telehealth.

> *"Making sure that... providers aren't practicing like they were 10 years ago because, if a patient hears something from one physician, and then hears something different from a different physician, it's hard for them to decide which physician to trust and listen to."*

IDENTIFYING AND BUILDING NEEDED INFRASTRUCTURE

Grantees described the need to build (and/or update) infrastructure to support service provision including developing workflow protocols, translating documents, setting up systems to collect and manage data, managing compliance with state and federal regulations, and offering resources specific to MAT clients' needs. Next, we describe each of these in more detail.

Developing workflow protocols.
In addition to hiring staff with the skills necessary to provide MAT services, grantees described the need to adapt and/or develop workflow protocols to integrate MAT services into their existing business processes. This was an ongoing process for most grantees, particularly as protocols were adapted to meet changing pandemic-related conditions and restrictions. Grantees also explained that it's critical for providers within the agency to have consistency in their approach to MAT induction (e.g., same clinical standards, same protocols for induction), as well as across the community of practitioners. One grantee created a handbook for providers on prescribing and managing patients in an office-based treatment setting. Another grantee continuously monitored and coached their providers to ensure alignment of services.

Translated documents.
Most grantees named the importance of having translated materials available. One grantee pointed out that, with frequent updates to policies and protocols, documents often need updating and agencies need to be prepared to obtain updated translations as well.

Setting up systems to collect and manage data.
Data collection and management is vital to quality service provision and for ensuring regulatory compliance. Grantees providing MAT embedded in behavioral health clinics explained that their electronic health records (EHR) were not set up to manage the data necessary to support MAT services,

regulations, and billing. For example, one grantee said that their EHR does not have the appropriate staff credentials to select for billing some MAT services. Moreover, the updates they were able to make to their EHRs were not always sufficient to meet their needs, e.g., one grantee created templates to append to cases in their EHR but had to manually search for the attachment when they needed to access the information.

Managing compliance with state and federal regulations.
Several grantees described the complexity of federal and state regulations around MAT service provision, and that they faced ongoing challenges aligning their internal processes to be in compliance. For example, one OBOT grantee described the difficulty of navigating Oregon Administrative Rules (OARs) for behavioral health clinics and those for physical health clinics. Another grantee hired a Director of Risk Management to sort out the rules. One agency also described a level of staff dissatisfaction due to the increased paperwork and administrative burden of implementing MAT.

Offering resources specific to MAT clients' needs.
Grantees described some of the more common barriers to clients accessing MAT that can be alleviated by having various resources available. For example, peers can provide transportation and help clients obtain resources (e.g., clothing, food, signing up for OHP). As another example, agencies can help clients set up email accounts to stay in contact. A grantee noted that clients will often use other people's email accounts but it creates issues with confidentiality as well as potential loss of access and gatekeeping by the owner. One last example is that agencies can help clients access equipment such as cell phones, computers, data plans, and/or internet service needed for telehealth (see Adapting MAT Services to a Telehealth Model for more information).

EFFORTS TO PROMOTE CONTINUOUS QUALITY IMPROVEMENT

The NIRN framework states the importance of having systems that support continuous quality improvement (CQI), including an organizational culture that values learning and improvement. One grantee explained that flexibility and planning for adaptations was important for implementing MAT services, and all agencies described making changes to better meet client needs and improve services.

Some of the examples of changes grantees made include:

- A grantee noticed that a barrier to client access to Narcan/naloxone was clients having to go to a pharmacy to pick up their prescription. Not only was this an inconvenience, it also potentially exposed clients to judgment from pharmacists due to stigma associated with IV drug use and MAT. The grantee collaborated with the pharmacy located next door so clinic staff can pick up the medication for their clients.

- A grantee identified the need to update their protocols for ambulatory induction of MAT in response to the spread of fentanyl in the community. Due to fentanyl's potency, clients were experiencing precipitated withdrawal with MAT induction. In response, they increased induction levels for clients using fentanyl by administering medication multiple times over a short period of time, and they provided clients with additional supportive medications and naloxone.

- A grantee's original program design was to schedule appointments for admissions; however, they noticed numerous missed appointments and realized the policy did not align with their goal to treat clients as soon as the client is ready. As such, they changed their admission policy to first come, first served.

Although grantees made program improvements, they lacked the time and resources needed to develop systems for tracking and analyzing data in support of quality improvement. For example, agencies described the need for funding for outreach efforts, but they did not have data available to help them identify which communities disproportionately faced barriers to access.

INTEGRATING PEER SUPPORT SERVICES

Previous research has shown that peers can be an important component of SUD treatment.[21] All agencies had peers on staff to help support clients through treatment and all but one funded peer positions (both new and existing) using SOR2 grant dollars. Grantees described how peers supported their clients including:

- Connecting them to resources such as food boxes, phones, and furniture;
- Finding housing, employment, and other social supports;
- Navigating services such as state insurance;
- Building relationships, providing emotional support, and role modeling; and
- Supporting clients in a client-directed manner.

Peers supported MAT services by doing outreach to clients (especially important for those who distrust the healthcare system), introducing clients to MAT services, working to overcome stigma associated with MAT, and motivating clients to stay engaged in treatment. Peers often acted as a bridge between the clinic and the community; they were positioned at EDs, probation offices, and shelters for the unhoused. Some peers were "on call" with other agencies (such as the ED) during normal workday hours. Peers also provided transportation to and from the labs, and connected clients to residential treatment and harm reduction supplies (e.g., Narcan, sterile injection equipment). Bilingual peers provided translation for their clients. At some agencies, peers connected clients to a primary care provider, and at bridge clinics, to long-term MAT providers. Additionally, peers helped clients find recovery groups that accept people getting MAT, and even facilitated virtual drop-in recovery group meetings.

Grantees also shared some of the challenges they experienced with integrating peers into MAT services including:

Background checks interfere with hiring. A grantee had trouble hiring peers due to their agency's restrictions related to background checks. To overcome this barrier, they partnered with a peer agency rather than hiring their own peers.

Lack of MAT-specific training for peers. Several grantees noted the need for MAT-specific peer training. One agency described using previously developed training protocols that included topics such as harm reduction and client engagement. They also adopted a model developed for peers providing support to clients with serious and persistent mental illness, but they noted that it was not sufficient for supporting MAT clients.

Sustainable funding. Although some services carried out by credentialed peers qualify for Medicaid reimbursement, some grantees were not clear on how to bill for those services and experienced challenges establishing sustainable funding streams for their peer workforce.

ADAPTING MAT SERVICES TO A TELEHEALTH MODEL

Telehealth-based MAT has been recognized as an approach to increase access to treatment for OUD, address the shortage of prescribers, and overcome geographical barriers.[22,23] Integrating telehealth can provide low-barrier treatment pathways and long-term continuity of care for clients.[24] Most agencies had plans to implement telehealth-based MAT to expand their services to rural areas, but the COVID-19 pandemic forced them to accelerate their plans. Grantees shared that telehealth created an easier pathway to MAT and some felt it reduced client no-show rates. Interestingly, one grantee said that telehealth helped them better understand their client's "day-to-day living experience" by getting a "glimpse into [their] living environment and outside world…because they are often taking their call at home, or in a tent on the street via candlelight…"

Grantees also noted difficulties implementing telehealth-based MAT, including the following:

- Navigating technology, the need for equipment (cell phones, computers), and internet access were challenging for both agency staff and clients.
- Protocols had to be designed to meet confidentiality requirements (such as electronic releases of information) and pandemic-related social distancing restrictions. For example, grantees required fewer in-person interactions and urine screenings with clients, which also interfered with their ability to do infectious disease screenings. Some agencies created telehealth suites, which allowed clients to have access to the technology (computers, webcams, and internet connection) and privacy required for their appointment. Furthermore, agencies moved to a hybrid model (telehealth and in-person) after COVID-19 to more flexibly serve clients.
- Some grantees said that connecting and building relationships with clients was more challenging with telehealth and described seeing lower client engagement, accountability, participation, and retention.
- Some staff found remote work to be impersonal because it afforded fewer opportunities to interact with and receive support from colleagues.

3 Workforce Development

The NIRN framework emphasizes the importance of staff recruitment and selection as a "beginning point for building a competent workforce that has the knowledge, skills, and abilities to carry out evidence-based practices with benefits to consumers".[25] The MAT workforce comprised various professional roles including physicians, counselors, peers, and administrative and operations personnel. In this section, we describe agencies' hiring efforts and the challenges they faced, as well as training efforts and support needed.

STAFF RECRUITMENT AND HIRING

The COVID-19 pandemic created staffing and hiring challenges for all agencies. Grantees described a constant need to fill staff positions including X waivered providers, Certified Alcohol and Drug Counselors (CADC I, CADC II), and peers.

The following are some examples of these challenges:

Shortage of X waivered providers.
Agencies experienced a shortage of X waivered providers, or those certified to prescribe buprenorphine outside of opioid treatment programs.[26] Consistent with previous research about the complexity of the X waiver process,[a] a grantee said that obtaining an X waiver was more arduous than necessary for being able to prescribe a medication. Another grantee noted that some doctors are reluctant to get involved with MAT services, contributing to the shortage.

Inadequate compensation.
Grantees described challenges related to chronically low wages in the field. Some offered bonuses and higher pay to attract applicants, especially for X waivered providers; however, it was difficult to sustain increases in compensation when reimbursement rates have not increased.

Credential requirements.
Grantees explained that RNs or LPNs must do medical dosing, but many who go into the nursing profession are more interested in working in hospitals and skilled nursing facilities (i.e., different interests and skill sets than what is needed for MAT). Moreover, grantees noted that CCOs can take 90 to 120 days to credential a provider, which, as shared previously, means the agency cannot bill for their work for several months after being hired.

Agency policies that interfere with hiring MAT staff.
As described earlier, one grantee had trouble hiring peers due to background checks that don't meet agency policies. This grantee also described agency policies that delay hiring and/or prevent hiring without funding from grants lasting longer than 24 months.

> *"A big barrier in this is doctor time. There are not a whole lot of doctors out there that are willing to jump into MAT."*

SUGGESTIONS FOR ADDRESSING WORKFORCE CHALLENGES

Grantees described various ways in which they dealt with ongoing hiring and staffing issues, and had some suggestions for addressing workforce challenges:

- One grantee worked with Portland Community College (PCC) to develop a pathway for hiring, and another grantee hoped to work with PCC to hire paid interns (e.g., CADC-Rs who are working on accruing the supervision hours required for a CADC I credential). These efforts reflect the need to develop a career ladder within the field.
- An agency asked local culturally-specific organizations to share job openings in their MAT program to encourage diverse applicants to apply.
- Several agencies lowered credential requirements when hiring certain positions. Grantees also began "growing their own" in response to the lack of applicants and the need for credentialed providers - they upskilled staff already on the job and paid for external training. They pointed to the need for scholarships and financial support for staff education, training, and credentialing, especially for Spanish-speaking providers and peers.

MAT Implementation Lessons Learned

The SOR2 MAT evaluation examined how grantees implemented MAT services in their agencies and the challenges they faced. The information summarized here reflects grantees' experiences as they worked to implement MAT services and navigate healthcare system regulations and policies, as well as issues specific to their agencies. Although these grantees' experiences may not fully represent all agencies implementing MAT services in Oregon or in other geographical locations, their lessons learned can help support organizations as they begin implementing MAT services. MAT implementation lessons learned are as follows:

Include key agency staff and diverse, knowledgeable informants in implementation planning.

Implementation committees should include key agency staff (e.g., financial advisors, operations managers, providers); community partners, especially culturally-specific organizations working with communities most affected by OUD; and individuals with lived experience with SUD (i.e., peers). Additionally, establish early connections with other organizations providing MAT and seek guidance and planning support from expert consultants if possible.

Assess staff readiness to implement MAT and design strategies to improve buy-in.

Some treatment providers have reservations about MAT. It might be necessary to promote organizational culture shifts from a drug-free orientation toward a harm reduction/MAT-first approach.

Assess community readiness for MAT services and design strategies to increase awareness and understanding.

Community members and clients with OUD often have misconceptions about MAT. Community outreach efforts (e.g., distributing materials, meeting with community leaders, public service announcements) can help educate people about MAT and approaches to harm reduction. These efforts should be linguistically and culturally inclusive (e.g., materials translated into multiple languages, working with culturally-specific community organizations). Examine community OUD treatment needs and possible utilization rates, especially when looking to provide MAT in rural areas (i.e., larger catchment area with fewer people).

Develop infrastructure to support service provision and regulatory compliance.

Update and create workflow protocols and practices to support staff in having a consistent approach to MAT service provision. It is important for agencies to align their internal processes with state and federal regulations and continuously monitor for compliance. Additionally, it is critical to collaborate with CCOs and private insurers to set up billing procedures that comply with their policies and regulations as soon as possible.

Develop data systems and an organizational culture that supports continuous quality improvement.

A system for tracking and analyzing data is a critical part of quality improvement - it can illuminate gaps in service, barriers to access, and other aspects of service provision in need of improvement. An organizational culture that values learning, flexibility, and adaptation will help agencies improve conditions for employees, and promote equitable outcomes for clients and communities.

Integrate peer support services with MAT service provision.

Peers should play a vital role in MAT service provision. Agencies should work to establish sustainable funding for the peer workforce and develop clear MAT-specific peer job descriptions. Once hired, agencies should provide MAT-specific training and support for peers, which will in turn enhance their ability to support clients.

Adapt MAT services to a telehealth model.

Establish a telehealth (or hybrid) option for MAT services to create a low-barrier pathway to treatment. Telehealth can help address the shortage of prescribers, overcome geographical barriers, offer flexibility to clients, and provide long-term continuity of care. It is especially important to have protocols designed to meet confidentiality requirements for telehealth appointments.

Plan for staffing shortages.

Anticipate and develop strategies for managing staffing challenges, including a shortage of X waivered providers, pay discrepancies, and credentialing requirements. Strategies will likely need to address internal policies (e.g., restrictive hiring policies), upskill existing staff, manage state and federal regulations (e.g., credentialing), and be proactive (e.g., talent pipeline).

2. Did SOR2 funding increase access to MAT services in Oregon?

The second evaluation question focused on whether SOR2 funding contributed to the strategic goal of increasing access to MAT services. To answer this question, PSU analyzed grantee progress reports for evidence of the extent to which MAT services were *available to* and *accessed by* people with OUD in Oregon.

Increased Availability of MAT services in Oregon

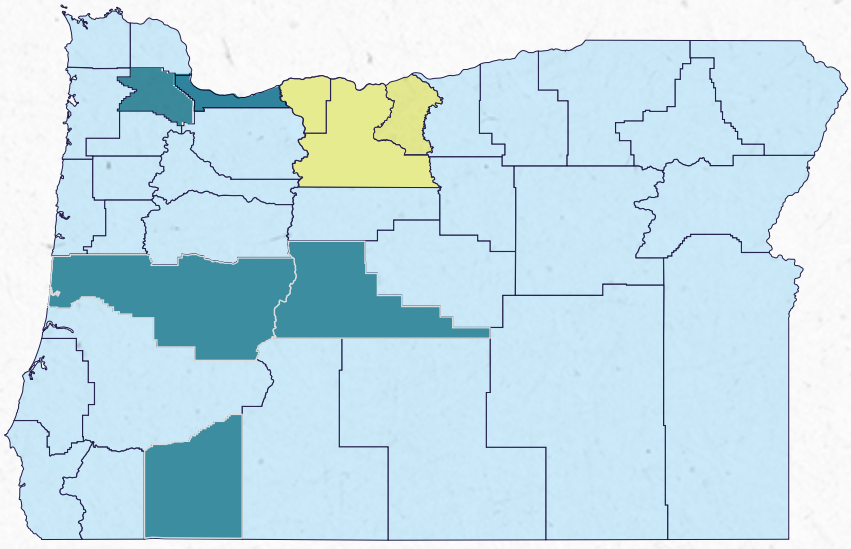
More counties with available MAT services

As seen in Figure 4, SOR2 funds were distributed to agencies providing MAT services in eight counties, three of which were new rural service areas: Hood River, Wasco, and Sherman. Thus, SOR2 funding contributed to expanding MAT services across the state and in rural communities.

Figure 4

Oregon counties with SOR2-funding MAT grantees

Multnomah
Hood River*
Wasco*
Sherman*
Lane
Deschutes
Washington
Jackson



*New MAT service areas

Clients received MAT services

Based on evidence from progress reports, these seven MAT grantees expanded the availability of MAT and peer services (e.g., Certified Recovery Mentors). Six of them implemented new MAT programs at their locations with SOR2 funding, and one grantee expanded their existing program. Grantee progress reports showed that over 2,800 people received OUD treatment, and nearly 1,500 people were treated with buprenorphine, during the SOR2 funding period. Importantly, grantees focused on providing rapid (same- or next-day), low-barrier access to MAT services, an approach to treatment that has been linked to appointment attendance[28] and improved retention rates, especially for Latine/Hispanic clients.[29]

More than

2,800

people received OUD treatment during the SOR2 funding period.

Expanded outreach efforts to increase access

Grantees reported that clients became aware of MAT services through their agencies' outreach efforts, referrals, and word of mouth. Progress reports included descriptions of efforts to develop infrastructure, hire staff, and collaborate with other agencies to expand access to MAT (see MAT Implementation Findings for more detailed information). Some examples specific to expanding access include:

- Partnering with CCOs to create a pathway for billing for MAT-first and MAT-only services without the need for a SUD assessment typically needed for service and treatment planning.
- Developing outreach materials to increase community awareness.
- Using telehealth to provide MAT services, which has been especially important for expanding availability in rural areas.
- Developing media campaigns for specific communities (e.g., Latine/Hispanic) and advertising on culturally-specific radio stations.
- Hiring a Care Transitions Coordinator to help patients find long-term prescribers for medication.
- Hiring bilingual/bicultural staff to provide culturally-responsive services in clients' preferred language.
- Developing agency policies and protocols for rapid access MAT services.
- Collaborating with the judicial system and EDs to develop referral pathways.
- Partnering with community organizations to provide culturally-specific MAT services (e.g., HRBR Clinic partnering with Mind Solutions to provide services in the African American/Black community).

As reflected above, many grantees employed strategies to promote equitable access to MAT services. Some also had specific goals related to expanding the availability of MAT services in priority populations, including incarcerated and probationary, Latine/Hispanic and Black/African American communities, rural or frontier regions, and people who accessed the ED due to SUD issues. A particularly important strategy to promote equity is partnering with a culturally-specific community organization. For example, one agency partnered with another non-MAT SOR2 grantee, which gave them the opportunity to participate in the Latino Provider's Meeting. This has increased their awareness of culturally-specific providers and helped them improve the cultural appropriateness of their services.

Efforts to expand access to infectious disease services

Some grantees also provided evidence of their efforts to increase clients' access to infectious disease screening, testing, prevention, and treatment. As part of the SOR2 evaluation, PSU conducted a sub-study designed to better understand infectious disease protocols for each of the MAT grantees (for more information, please see the *State Opioid Response Grant II Impact Evaluation: Final Report*[*]). Four of the seven grantees included in the MAT evaluation provided some level of routine infectious disease risk assessments and testing and/or referrals for testing. The other three were in the initial phases of developing these services.

Grantees also described several challenges in doing this work and pointed to many of the same issues they experienced when implementing MAT services including billing, especially when providing medical services in a behavioral health setting; staffing and the need for ongoing training; infrastructure and protocol development, particularly when overlaying medical care in a formerly behavioral care-only setting; and coordinating with other agencies. Grantees also mentioned the need to broaden public health campaigns for PrEP (for HIV prevention) to include people who inject drugs and the need to improve testing services, especially for those who have damaged veins from IV drug use (e.g., incentivize blood draws with gift cards, increase access to Dried Blood Spot testing).

[*]This report is available upon request. Please contact Kelsey Smith-Payne at the Oregon Health Authority: kelsey.smithpayne@dhsoha.state.or.us

Summary of MAT Availability and Implications

Overall, the available evidence suggests that SOR2 funding contributed to the increased availability of MAT services in Oregon. Grantees described outreach efforts, reported serving more than 2,800 clients, and many were striving toward goals to improve equitable access to MAT services. Agencies also made some progress toward their goals related to expanding MAT clients' access to infectious disease screening, testing, prevention, and treatment. However, there was not enough evidence to thoroughly evaluate the impact of their outreach efforts. Agencies often did not have the capacity, for example, to track outreach at the client level or to disaggregate data to examine potential disparities in their service delivery for marginalized groups (e.g., race, immigration status, LGBTQIA+).

SOR2 funding contributed to the increased availability of MAT services in Oregon.

These findings also suggest several ways to improve access to MAT and related services:

Focus funding on priority populations. Channeling funding and resources toward identified priority populations can promote equitable access to services. SOR2 funding, for example, intentionally expanded access to MAT services in rural communities. Future funding could use the same approach to expand access to other populations experiencing the disproportionate impact of OUD (e.g., tribal communities, people who are unhoused, incarcerated, youth, veterans).[30]

Incentivize equity goals. Some grantees had goals for providing equitable access to MAT services, and named specific priority populations (e.g., Latine/Hispanic). Incentivizing future grantees to intentionally develop and demonstrate progress toward their equity goals will help drive the SUD system toward an equitable distribution of culturally- and linguistically relevant MAT services.[31]

Involve people with lived experience. Many MAT grantees integrated peers in their array of services to clients. In alignment with SAMHSA's *Participation Guidelines for Individuals with Lived Experience and Family*, grantees could also be encouraged to involve peers/people with lived experience in designing their programs, including client outreach, engagement, and retention.[32]

Fund, and/or support capacity building for, culturally-specific organizations to provide MAT services. For example, the second year of SOR2 funding included tribal grantees working to expand their MAT services. Supporting culturally-specific organizations will create more opportunities for culturally- and linguistically-relevant SUD treatment and promote health equity.[33]

Increase funding and technical assistance for organizations to further develop their infectious disease testing protocols. Doing so will help future grantees better integrate their response to the dual epidemic of OUD and infectious disease.[34]

3. To what extent did people with OUD use and benefit from SOR2-funded MAT services?

The final MAT evaluation question focused on client outcomes. PSU used GPRA data to examine whether expanded access to MAT services resulted in the use of these services, and the extent to which clients experienced associated benefits in terms of reduced substance use, quality of life, system involvement, and life satisfaction.

Use of MAT services and retention

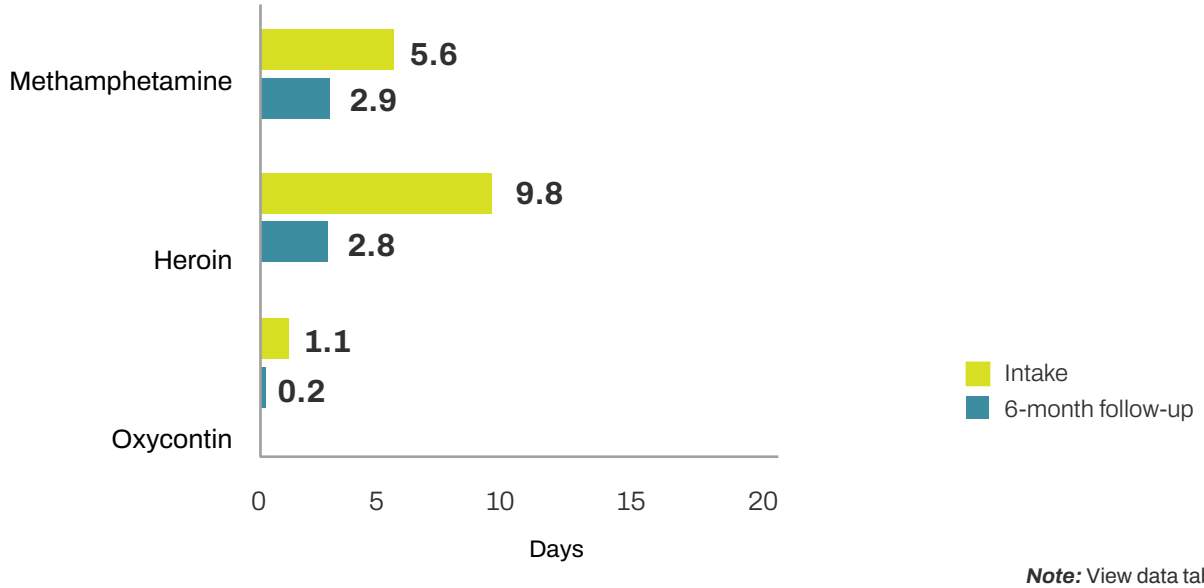
From October 1, 2020 to June 30, 2022, 1048 clients participated in the GPRA client outcome interview. Of those 1048 clients, 354 (34%) of them also completed the 6-month follow-up GPRA interview.* Although 34% is not a true retention rate for MAT clients, it does suggest that it is challenging to support clients in remaining engaged in treatment.

Reduced past 30-day drug use

MAT clients with both intake and 6-month follow-up GRPA data reported a decrease in the number of days they used methamphetamine, heroin, and oxycontin in the past 30 days (see Figure 5). It is noteworthy that other types of opiates followed this same pattern but were not statistically significant (e.g., morphine, Percocet, non-prescription methadone, Dilaudid).

Figure 5

Number of days MAT clients used drugs in the past 30 days



Note: View data table here.

*Although this represents a proportion of clients still engaged in MAT services after six months, it also reflects missing data. Many agencies expressed challenges administering the GPRA survey. At the beginning of SOR2, some agencies were not able to collect GPRA data because they needed to train staff to administer the survey; later, staff turnover interrupted data collection. It was also challenging to conduct follow-up surveys due to clients transferring out of the program and no-shows. Thus, the clients in the 6-month follow-up sample may not represent the actual client population.

Less injection drug use

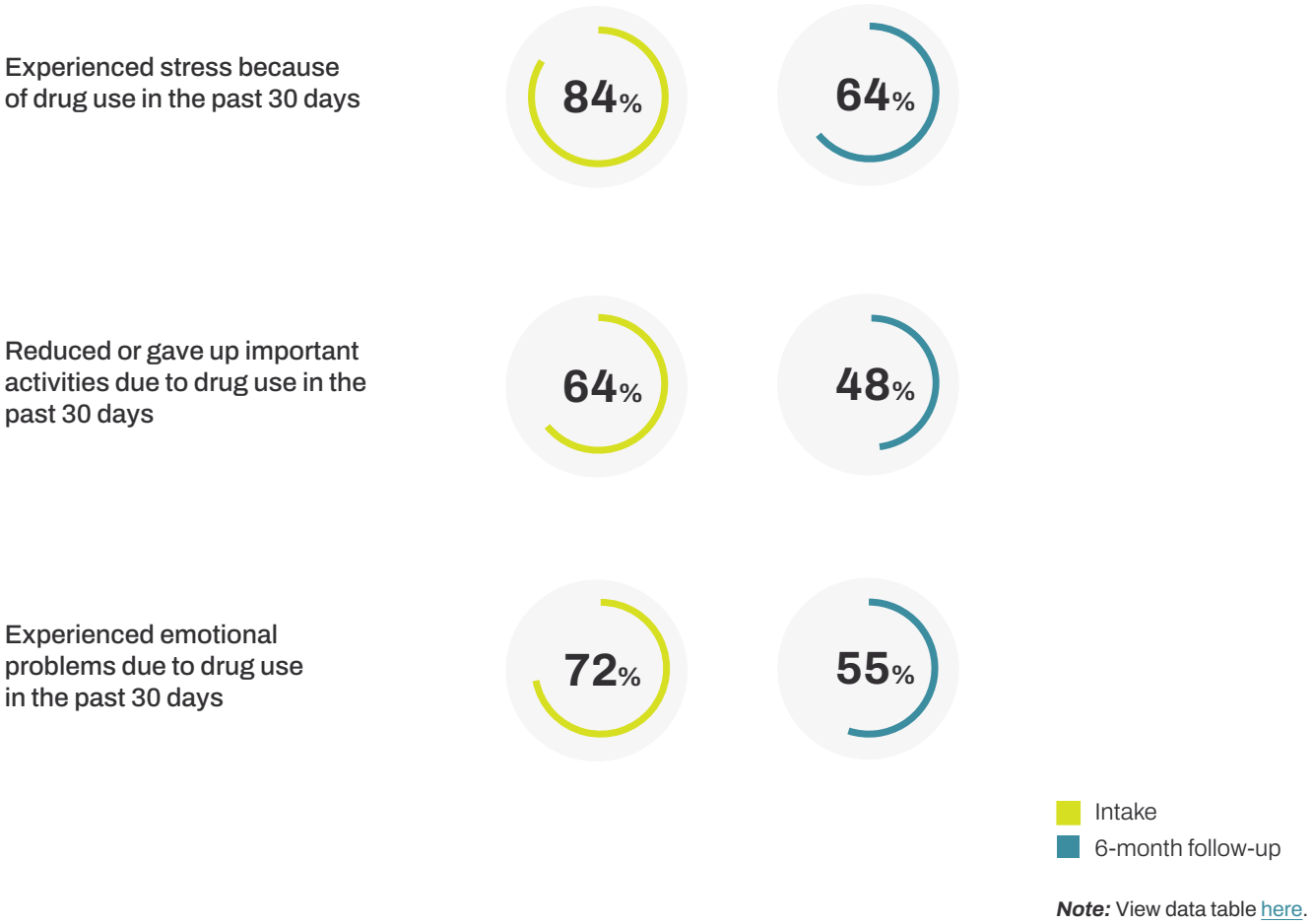
A smaller share of MAT clients reported injecting drugs at six months compared to intake (25.5% and 34.8%, respectively (n=325); chi square=51.58, p<.001).

Reduced adverse effects from drug use

A smaller proportion of MAT clients experienced adverse effects from drug use (stress, reduced activities, and emotional problems) in the past 30 days at the 6-month follow-up than at intake (see Figure 6).

Figure 6

Change in MAT clients' adverse effects from drug use from intake to 6-month follow-up



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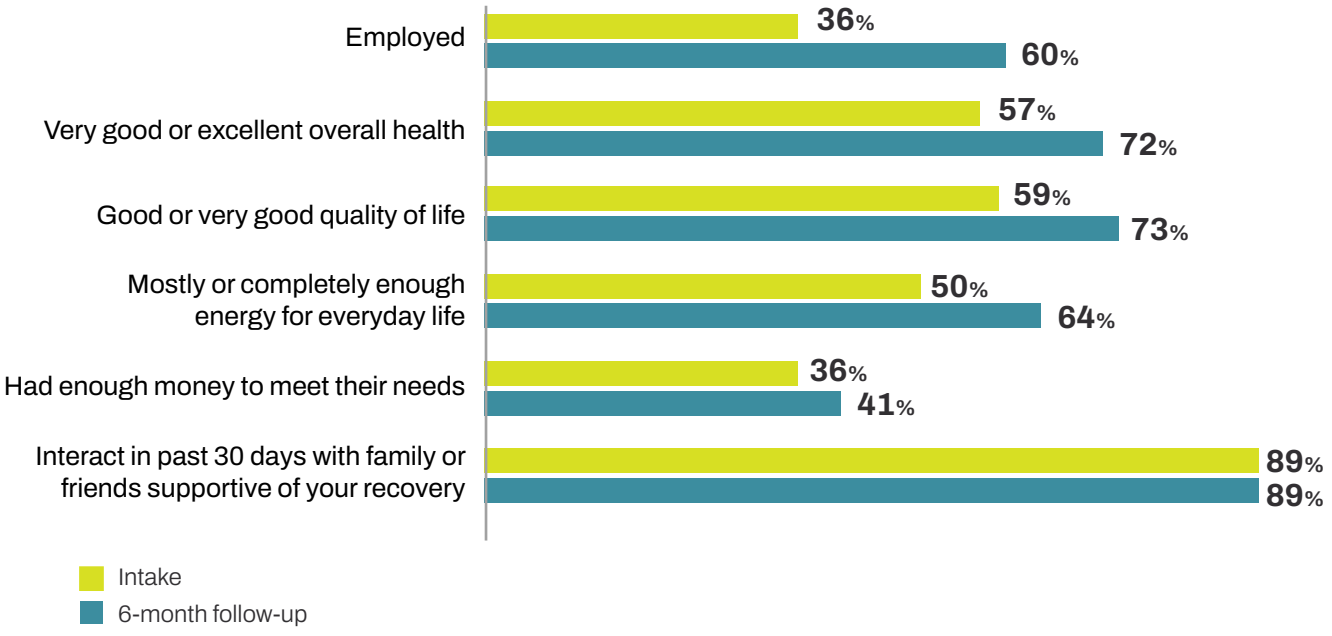
Improved Quality of Life

Figure 7 shows changes in various indicators of MAT clients' quality of life from intake to the 6-month follow-up. Overall, MAT clients reported the most substantial (and statistically significant) improvements in terms of employment, quality of life, overall health, and having enough energy for everyday life from intake to the 6-month follow-up interview. More specifically:

- There was an increase in the percentage of clients reporting they were employed and had enough money to meet their needs (not statistically significant).
- A larger share of clients indicated they had *very good* or *excellent* overall health and *good* or *very good* quality of life.
- An increased proportion of MAT clients reporting that they had mostly or completely enough energy for everyday life.
- Nearly nine in 10 clients reported having interactions with supportive friends and family at both time points (no change from intake to 6-month follow-up).

Figure 7

Change in MAT clients' quality of life from intake to 6-month follow-up



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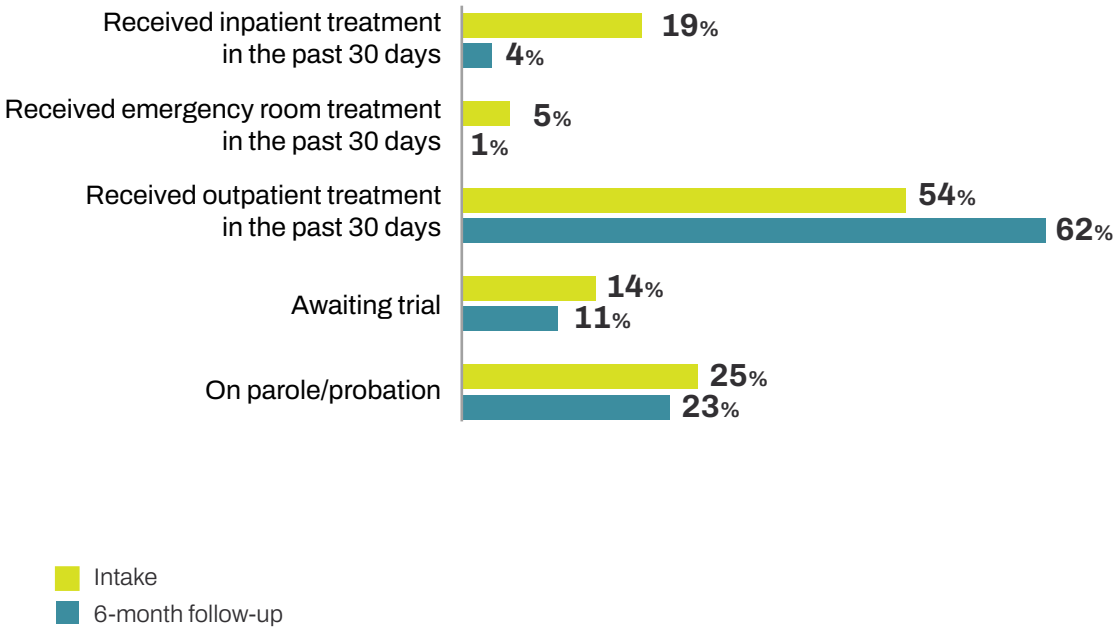
Reduced System Involvement

MAT clients also reported less system involvement at the 6-month follow-up (see Figure 8). Specifically, a smaller proportion of MAT clients received emergency room treatment and inpatient treatment for alcohol and substance use in the past 30 days. There was a smaller share of clients awaiting trial or on parole/probation at the 6-month follow-up, although these differences were not statistically significant. A significantly larger proportion of MAT clients received outpatient treatment at the 6-month follow-up.

Combined with reduced emergency room and inpatient treatment, this finding could signal fewer overdoses and hospitalizations, and the movement of clients to less restrictive levels of care as they manage their OUD.[35]

Figure 8

Change in MAT clients' system involvement from intake to the 6-month follow-up



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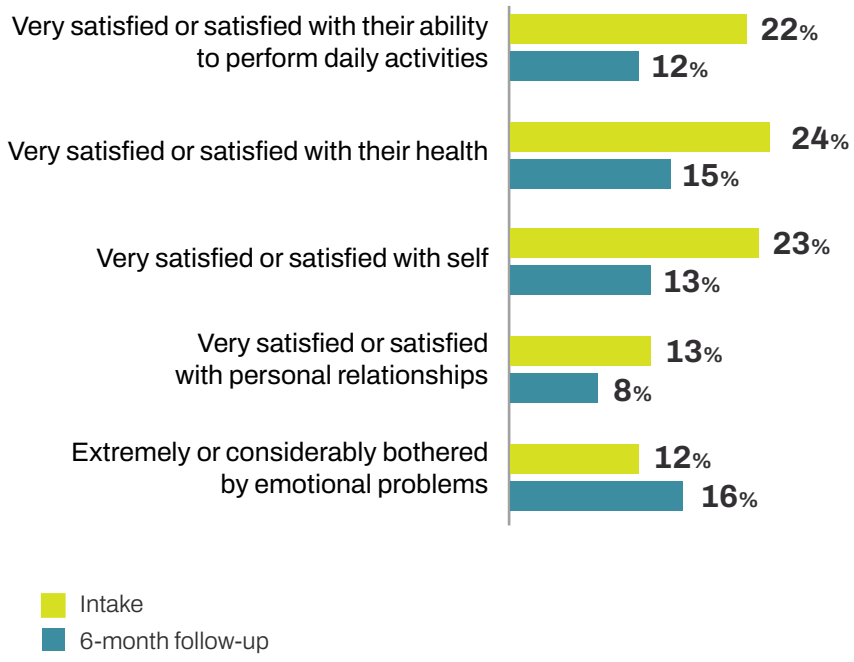
Lower Life Satisfaction in Early Treatment

In contrast to the findings already reported, MAT clients experienced *lower* life satisfaction six months after intake (see Figure 9). MAT clients reported statistically significant decreases in their satisfaction with performing daily activities, their health, themselves, and with their relationships. There was an increase in the proportion of MAT clients who reported being *extremely* or *considerably* bothered by emotional problems, but the difference was not statistically significant.

Figure 9

Change in MAT clients' life satisfaction from intake to 6-month follow-up



Note: View data table here.

Summary of MAT Utilization & Implications

Taken together, findings from the analysis of GPRA data suggest that during the SOR2 funding period, individuals with OUD used MAT services, and for those who completed a 6-month follow-up interview, experienced benefits in terms of reduced substance use and system involvement, and improved quality of life. Next, we discuss the implications of these findings and for the future expansion of MAT services.

MAT clients had reduced opioid and methamphetamine use, and decreased injection drug use six months after intake.

Client retention in MAT services might be challenging.
One-third of MAT grantees (34%) who participated in a GPRA interview at intake were interviewed again six months later. Although this is not a true retention rate (i.e., it reflects missing data due to challenges administering the GPRA survey and with client follow-up), it is in line with 6-month retention rates in other studies. In a systematic review of 55 studies, 6-month retention rates ranged from 3% to 88%.[36] Another review found that 6-month retention rates for MAT are typically below 50%.[37]

We were unable to assess equitable outcomes for clients in terms of retention, which is important for identifying systemic barriers that may disproportionately affect some groups. For example, prior research has shown lower retention rates for Black and Latine/Hispanic clients, clients who are unemployed or have lower incomes, and younger adults.[38,39]

Retention in MAT is associated with better outcomes, such as decreased drug use, improved quality of life, and reduced mortality.[40] As such, it is important for future MAT providers to find strategies to promote retention, such as peer support services,[41,42] and psychosocial support.[43] It is also important to identify and actively work to remove systemic barriers to promote equitable outcomes for clients. Longer term follow-up periods and larger samples are necessary to further evaluate retention rate.[44]

Participation in MAT services was associated with reduced drug use, improved quality of life, and reduced system involvement.
Findings suggest that MAT clients had reduced opioid and methamphetamine use and decreased injection drug use, which is consistent with previous studies.[45,46,47] Reduced drug use is encouraging to see in the short-term, but it is important to assess the longer-term association between MAT and reduced drug use.

MAT clients indicated an overall improvement in their quality of life. A larger share of clients were employed, and felt like they had enough money to meet their needs, better overall health, and enough energy for everyday life. These results suggest that MAT can improve the quality of life for those with OUD, which is consistent with previous studies.[48,49,50]

There was less system involvement for MAT clients over time. MAT clients reported reduced use of emergency services and inpatient SUD care. OUD creates a significant economic burden for the healthcare system due to a higher number of ED visits, and higher pharmaceutical and medical costs.[51] These findings suggest MAT services have the potential to reduce the burden and costs to the healthcare system as these services are less used.

Additionally, there was a reduction in the proportion of MAT clients who were awaiting trial or on parole/probation. The criminal justice system faces greater burden due to the opioid epidemic, as the odds of being arrested or involved in the system is significantly greater for those with OUD.[52] Studies have shown that integrating MAT into the probation and parole system can help reduce recidivism.[53,54,55] Taken together, these findings suggest that access to MAT services has the potential to lessen the burden on the justice system for people on parole or probation.

MAT clients were *less* satisfied with various aspects of their lives early in recovery. Overall, MAT clients were less satisfied with themselves, their relationships with others, their health, and with performing daily activities compared to when they first started treatment. A phenomenon known as the "pink cloud syndrome" could explain the reduction in life satisfaction for MAT clients. The pink cloud is often used to describe the early stages in treatment where people have a temporary sense of joy and euphoria without the haze of intoxication.[56] This creates a false sense of well-being at the beginning of their treatment. As the effects are temporary, people are often left feeling less satisfied with some aspects of their lives (e.g., managing household responsibilities, performing daily activities, interactions with others) when the euphoric feelings wear off.[57] Future MAT agencies should ensure they are able to connect clients to resources for long-term recovery support, such as counseling, peer support services, group support, and education to help them work through these feelings as part of relapse planning. As well, future evaluation work could follow clients for a longer period of time to examine whether satisfaction increases in the longer term.

MAT Evaluation Key Findings & Recommendations

The goals of this MAT evaluation were to understand 1) how MAT services were implemented and what challenges were associated with implementation, 2) if SOR2 funding increased access to MAT services in Oregon, and 3) the extent to which people with OUD used and benefited from SOR2-funded MAT services. The following is a summary of key findings pertaining to MAT implementation and the impact of SOR2 funding on expanding access to MAT services in Oregon, as well as recommendations for future expansion.

MAT Implementation Key Findings

During the SOR2 funding period, the seven agencies included in this evaluation provided new or expanded existing MAT services at their agencies in response to growing numbers of opioid-related overdose deaths in their communities. The following is a summary of how grantees implemented MAT services in their organizations, the factors that facilitated the adoption of MAT, and challenges they faced.

SOR2 funding allowed grantees to provide new and expanded MAT services, but they needed additional implementation support. The SOR2 grant provided the funding and technical assistance from OHA that grantees needed to launch new and expanded MAT services. However, all grantees needed additional support from experts, other more well-established MAT programs, and/or other knowledgeable partners. They also suggested it would have been useful to have dedicated time to meet with MAT agency colleagues to reflect on their programs, discuss challenges, and brainstorm solutions.

Grantees experienced successes due to their flexibility, willingness to make improvements, and collaboration with community partners. Grantees navigated COVID-19 restrictions and adjusted their protocols and services as needed, even when agencies around them were closing. They also recalibrated policies and procedures to meet reimbursement and state and federal regulatory requirements, and made programmatic changes in response to client needs. Many of the improvements made were in collaboration with community partners (e.g., local pharmacies, jails, EDs). Finally, they found innovative solutions in the face of workforce shortages (e.g., partnering with a telehealth MAT provider). Grantees should leverage their successes in these areas to continue improving and expanding their programs.

Grantees encountered challenges related to reimbursements for services, agency resistance toward MAT, staffing/hiring, and data management. Although several grantees collaborated with CCOs to understand billing requirements and develop simplified pathways to services, nearly all of them faced challenges getting reimbursed. Most grantees experienced organizational and/or staff resistance to MAT and had to develop strategies to shift mindsets toward a harm reduction approach. Agencies also struggled with hiring and used multiple strategies to maintain their workforce (e.g., upskilling existing staff, pay increases, shifting positions and workloads). Last, several grantees did not have data systems in place to support MAT service tracking, billing (especially for behavioral health agencies), and continuous quality improvement. These are all areas in which grantees would benefit from additional funding, technical assistance, and state or federal advocacy.

Expanded Availability & Utilization of MAT Services Key Findings

SOR2 funding contributed to the increased availability of MAT services in Oregon. Grantees described outreach efforts, reported serving over 2,800 clients, and worked toward goals to improve equitable access to MAT services. They also made some progress toward expanding access to infectious disease care as part of their efforts to expand MAT. However, more evaluation is needed to understand the impact of their outreach efforts and whether they were equitable.

Individuals with OUD used MAT services, and experienced benefits in terms of reduced substance use and system involvement, and improved quality of life. Specifically, participation in MAT services was associated with reduced drug use, improved quality of life, and reduced system involvement (e.g., criminal justice). At the same time, clients' satisfaction with their lives declined, pointing to the need for MAT providers to connect clients to resources for long-term recovery support, such as counseling, peer support services, group support, and education to help them work through these feelings as part of relapse planning.

Client retention in MAT services might be challenging. Although we did not have a true retention rate, only one-third of MAT clients had a 6-month follow-up GRPA interview. It is important for MAT agencies to find strategies to promote retention (e.g., peer support services, psychosocial support), and to identify and actively work to remove systemic barriers in order to promote equitable outcomes for clients.

Recommendations for Future Expansion of MAT in Oregon

Based on findings from the SOR2 MAT Evaluation, we offer the following recommendations to support the future expansion of MAT services in Oregon.

Allocate more resources for implementation. Implementing MAT services requires funding, staff time, technical assistance, and infrastructure investments (e.g., data systems). Future expansion efforts should allocate a proportion of funding specifically for implementation, and support agencies in connecting with technical assistance, expert consultants, and learning communities with other MAT providers. If grantees are encouraged or required to offer infectious disease care, they need funding and technical assistance to help them integrate their response to the dual epidemic of OUD and infectious disease. A longer funding period would also provide more time and resources for implementation. The two-year SOR2 funding period essentially required agencies to fully implement MAT services without time for thorough planning and installation.

Continue funding work in priority populations. Intentionally identifying and funding services for priority populations can promote equitable access to services. SOR2 funding, for example, intentionally expanded access to MAT services in rural communities. Future funding could use the same approach to expand access to other populations experiencing the disproportionate impact of OUD. Funding should also incentivize agencies to adopt and strive toward goals for providing equitable access to MAT services. Last, fund culturally-specific organizations to create more opportunities for culturally- and linguistically-relevant MAT services and promote health equity.

Intentionally identifying and funding services for priority populations, incentivizing agencies to adopt equity goals, and funding culturally-specific agencies can promote health equity.

Encourage agencies to involve people with lived experience. In alignment with SAMHSA's *Participation Guidelines for Individuals with Lived Experience and Family*, encourage agencies to involve peers/people with lived experience in designing their programs, including client outreach, engagement, and retention. Agencies should also be incentivized to collect client feedback on their experiences with MAT services to better assess whether they are culturally-responsive, trauma-informed, and client-centered, and on areas for improvement.

Invest in the SUD workforce. Hiring and retaining high quality staff was one of the main challenges grantees faced. State and federal investments in the SUD workforce could help increase wages, expand training opportunities, increase the number of credentialed providers, and develop a career ladder in the field (e.g., support paid internships for CADC-Rs). Removing financial barriers (e.g., scholarship programs) would encourage more people to enter the SUD field, and financial incentives for priority provider populations (e.g., Spanish-speaking) would create more equitable workforce opportunities. Importantly, workforce efforts should also focus on removing barriers to accessing higher education that disproportionately affect certain communities (e.g., ethnic/racial minority groups, low-income students)[58,59,60] and result in less culturally and linguistically diverse healthcare workforce.

Support grantees' understanding of state and federal policies and advocate for any needed changes. As MAT expands across Oregon, it will be important for agencies to fully understand and navigate state and federal policies pertaining to MAT service provision. Some examples of regulations that grantees found challenging to navigate or would like to see changed are the Suboxone certification process, MAT location restrictions, and rules that do not allow methadone admissions over telehealth (for OTPs). Additional support developing cost calculators, negotiating fees with CCOs and private insurance providers, and finding ways to be reimbursed for outreach activities would support agencies' financial sustainability. Another area for advocacy is credentialing, which can place limits on who can provide services (e.g., restrictive background checks for peers) and create gaps in funding if there is staff turnover (e.g., processing time when CCO's credential providers).

Investing in the SUD workforce should include increasing wages, expanding training opportunities, developing a career ladder, and removing financial and other barriers to education and credentialing.

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Table 1

MAT client race/ethnicity at intake

Race/ethnicity	% (n)
Alaska Native	1% (15)
Asian	1% (6)
Black	4% (38)
Latine/Hispanic	10% (102)
Native American	5% (56)
Native Hawaiian	1% (7)
White	90% (938)

Note. Clients could select more than one category.
Data featured in Figure 3.

Table 2

Number of days MAT clients used drugs in the past 30 days at intake and 6-month follow-up

Type of drug (n=345)	Intake	6 month follow-up	Effect size Cohen's d, Significance (p value)
Methamphetamine	5.60	2.91	0.28, p<.001*
Heroin	9.75	2.82	0.58, p<.001*
Oxycontin	1.14	0.21	0.18, p=.001*
Morphine	0.28	0	0.10, p=.05
Percocet	0.11	0	0.08, p=.15
Non-prescription Methadone	0.23	0.07	0.06, p=.24
Dilaudid	0.28	0.01	0.06, p=.31

** p values <.05 indicate a statistically significant difference.*
Data featured from Figure 5.

Table 3

Change in MAT clients' adverse effects from drug use from intake to 6-month follow-up

Type of adverse effect	**n**	**Intake**	**6 month follow-up**	**Effect size** Cohen's d, Significance (p value)
Experienced stress because of drug use in the past 30 days	154	83.77%	64.29%	22.13, p<.001*
Reduced or gave up important activities due to drug use in the past 30 days	151	64.24%	47.68%	12.80, p<.001*
Experienced emotional problems due to drug use in the past 30 days	152	71.71%	55.26%	11.76, p<.001*

** p values <.05 indicate a statistically significant difference.*
Data featured from Figure 6.

Table 4

Change in MAT clients' quality of life from intake to 6-month follow-up

Quality of life indicator	**n**	**Intake**	**6 month follow-up**	**Effect size** Chi-square, p value
Employed (yes/no)	290	36.20%	60.00%	47.67, p<0.001*
Very good or excellent overall health	348	57.47%	71.55%	21.94, p<0.001*
Good or very good quality of life	344	58.70%	73.00%	11.76, p<.001*
Mostly or completely enough energy for everyday life	349	50.14%	63.90%	17.26, p<0.001*
Had enough money to meet their needs	350	36.00%	41.40%	2.73, p=0.10
Interact in past 30 days with family or friends supportive of your recovery	343	89.21%	89.21%	0.02, n=0.89

** p values <.05 indicate a statistically significant difference.*
Data featured from Figure 7.

Table 5

Change in MAT clients' system involvement from intake to the 6-month follow-up

Indicator of system involvement	n	Intake	6 month follow-up	Effect size Chi-square, p value
Received inpatient treatment in the past 30 days	346	19.36%	3.47%	43.52, p<0.001*
Received emergency room treatment in the past 30 days	346	4.62%	0.58%	9.39, p=0.002*
Received outpatient treatment in the past 30 days	340	53.82%	62.06%	8.89, p=0.003*
Awaiting trial	345	13.62%	10.43%	2.13, p=0.15
On parole/probation	349	24.93%	22.64%	0.87, p=0.35

** p values <.05 indicate a statistically significant difference.*
Data featured from Figure 8.

Table 6

Change in MAT clients' life satisfaction from intake to 6-month follow-up

Life satisfaction indicator	n	Intake	6 month follow-up	Effect size Chi-square, p value
Very satisfied or satisfied with their ability to perform daily activities	348	21.55%	12.07%	15.28, p<0.001*
Very satisfied or satisfied with their health	345	23.77%	14.78%	14.75, p<0.001*
Very satisfied or satisfied with self	349	22.83%	13.18%	14.42, p<0.001*
Very satisfied or satisfied with personal relationships	340	13.24%	8.24%	5.69, p=0.02*
Extremely or considerably bothered by emotional problems	194	12.37%	16.49%	1.75, p=0.19

** p values <.05 indicate a statistically significant difference.*
Data featured from Figure 9.

Appendix A: Initial Interview Questions

Implementation

How long has your organization been delivering MAT services?

Why did [organization name] decide to implement/expand MAT services?

Can you tell me about your planning process?

[Probes: How did you discover the need for MAT? Did your organization apply a health equity lens in planning? If yes, how did you apply a health equity lens? (e.g., identify groups that aren't being served or disproportionately face barriers to access; strategies for outreach) Who was included in the planning (e.g., community members, community-based organizations)?]

What other services do you provide in conjunction with MAT services? (eg. Peer Recovery Mentors)

How do these services integrate with MAT services?

Staffing

In the last SOR2 progress report, we read that hiring has been challenging for a number of MAT providers.

Can you tell me more about that?

What qualifications or credentials are needed to administer MAT services?

What are some of the barriers your agency faced? (e.g., pay rate and cost of living, history of criminal justice involvement, finding staff that reflect the population served).

How do hiring barriers impact the clients you serve?

How did hiring/staffing barriers impact the implementation process?

What is your agency doing to overcome these barriers?

Organizational Commitment

People hold different opinions or perceptions of MAT as a SUD treatment modality.

What is your organization's stance on MAT?

How do other staff at your agency regard MAT?

How do clients view MAT?

How do your community partners generally regard MAT?

Does your organization promote/have plans to promote MAT as an evidence-based practice for SUD?

If already promoting: what works?

Financial or regulatory issues

Do you anticipate/have you experienced any issues with receiving payment for services (e.g., Medicaid)?

[Probe: Does billing/payment create obstacles for some people in accessing or receiving MAT services?]

Do you anticipate/have you experienced any regulatory issues related to providing MAT services?

Health equity/culturally responsive services

How does your organization ensure that clients receive culturally responsive services?

Research shows there are barriers to accessing SUD services which may disproportionately affect certain groups (based on race, gender identity, income, preferred language).

What does your organization do to identify and remove those kinds of barriers to accessing MAT services?

Telehealth

Does your organization provide telehealth/telemedicine services for MAT?

If yes:
When and how did your agency shift to telehealth?

What were some of the infrastructure needs and how were they addressed?

What are the strengths of telehealth? For whom does it work well for and why?

What are the challenges of telehealth?
Are there some groups of clients who face more barriers than others?

What are your staff's experiences of telehealth?

If no:
Does your organization have plans to provide telehealth services?

If yes, when and how? If no, why not?

Data Collected

OHA is looking at the possibility of having all of the MAT expansion grantees report on a small set of common metrics to help us understand the impact of SOR2 funds.

What types of data does your organization collect (aside from GPRA data)?

Do you collect any of the following information:

- Client demographics
- Number of clients served, types of medication
- Treatment duration/retention, re-entry
- Number of clients served by telehealth
- Where referrals are coming from
- Where you are referring clients (e.g., other treatment programs, community service array)
- Other types of data?

Does your agency have any program reports that you can share with us?

Connections to Larger Systems of Care

Describe the collaborative partnerships you have made since the expansion of the MAT program.

> [Probes: Were any of the collaborations with other MAT providers? Have any of these partnerships been formalized for ease of future collaboration? Are there key staff for creating and maintaining partnerships with other organizations? How is that work done at your organization?]

Can you describe how your organization helps coordinate care for clients who are going to work with other agencies?

What is successful?

What is challenging?

COVID-19

How has the COVID-19 pandemic changed processes or procedures that were implemented for the MAT program?

Is your organization keeping any of the changes made due to COVID-19 going forward?

How did the COVID-19 pandemic impact collaboration with your partners?

Appendix B: Follow-up Interview Questions

Health Equity

Can you describe some of the barriers to getting clients with Opioid Use Disorder on MAT?

Are there certain groups of people that stand out as facing additional or specific barriers (such as those with disabilities, certain races or ethnicities, non-English speaking folks, gender differences, transgender, etc.)?

Has your agency been able to work to address specific barriers? Are there certain populations your agency is working to expand services to?

What are some things that would help your agency or staff work to expand services to underserved populations? Are there barriers such as funding or training that get in the way?

What do you do if a client asks for additional culturally specific services? Do you have connections with culturally specific agencies to refer clients to if those services aren't available at your agency?

During our previous interview, a number of MAT providers talked about trying to hire diverse staff to help ensure they were providing more culturally-responsive services– but hiring has been a huge issue across the state.

How is hiring going for your organization?

Was diversifying staff one of your agency's goals?

If yes: what steps have you taken to reach and retain a more diverse staff?

Where is additional workforce support needed? (E.g., finding/hiring: X waivered prescribers, mentors, admin, counselors… Or training and credentialing? Diversity?)

Implementation

If another agency was thinking about integrating MAT into their services, what would you tell them to prepare for? What should be first on their to-do list?

What were the key supports or what supports do you wish you had in implementing this service?

Who are the key people or organizations to make sure to include in planning?

Are there Oregon-specific recommendations?

Have you made any changes/improvements to the program? Can you give me some examples?

How did you know to make those changes? Would you be able to describe your process for identifying when changes are needed and then making those changes?

Service Models and Service Integration

Can you briefly describe how the process would look for a client wishing to begin treatment for opioid use disorder at your agency?

[Probe: For example, do you follow a model such as MAT first?]

Do you know how clients are finding your services?

We would like to hear more details about the role of peers in MAT.

Can you tell me a little about their job description?

Is there additional training needed for a Peer Support Specialist or CRM coming to work with MAT clients?

What's most important or what's the focus of the MAT CRM?

Stigma

It is well documented that there is misunderstanding and resistance against MAT in some communities.

What could be helpful for other organizations implementing MAT programs to help with resistance and misconceptions against MAT?

How do these misconceptions/resistance affect client engagement in treatment?

[Probe: How can an organization support clients through their biases in staying or coming in for treatment?]

What are you doing as an organization to make a more welcoming environment for people seeking MAT? Eg. What are you doing to help people see that MAT is a treatment option for them?

[Probes: What are some efforts to decrease stigma and organizational resistance to MAT? Does the organization have any workforce training and support in this area?]

Billing Q's

What would be your recommendations to an agency such as yours preparing to implement MAT with regards to billing and reimbursements?

Do you have recommendations for how to work with CCOs for reimbursement?

We know agencies that provide a medication first model have encountered problems with getting reimbursed. Have you developed protocols for getting reimbursed without having to first do all the medical screening and SUD assessments so you can get clients in sooner?

[Probe: If yes, can you tell me about those protocols? What would you recommend to other agencies encountering these problems?]

Have CCO billing and reimbursement requirements affected services for clients? (e.g., when dealing with different CCO requirements when clients live in different counties from where they are receiving services)

[Probe: What requirements have been the biggest barriers? Have you found any solutions? (are those solutions temporary or CCO-dependent or can you also provide recommendations for other agencies)?]

Regulations

What do you know about DEA and OHA prescribing requirements?

Have you had any barriers and challenges to prescribing requirements?

What are some suggestions for other new or expanding MAT providers in dealing with regulations and billing?

Telehealth

How do you support engagement over telehealth?

How has telehealth changed since 6 months ago (Eg. first interview)?

What would be some recommendations you would give to other new or expanding MAT programs on telehealth?

Wrap up

Is there anything that wasn't mentioned here today that could be helpful for OHA to know in order to better help others expand or implement MAT services? Do you have any recommendations or highlights to share?

Appendix D: State Opioid Response Grant 2: Medication Assisted Treatment Expansion Lessons Learned

STATE OPIOID RESPONSE 2 GRANT:

Medication Assisted Treatment Implementation Lessons Learned and Recommendations

Authors (alphabetical):
Christine Cooper
Carrie Furrer
Yumi Lee

Portland State University Contact:
Yumi Lee
yumi.lee@pdx.edu

Oregon Health Authority Contact:
Kelsey Smith-Payne
kelsey.smithpayne@dhsoha.state.or.us

The Substance Abuse and Mental Health Services Administration (SAMHSA) funded a fiscal year (FY) 2020 cohort of the State Opioid Response grant program (referred to here as SOR2). The purpose of SOR2 was to address the opioid crisis by providing resources for increasing access to FDA-approved medication for the treatment of opioid use disorder and supporting the continuum of prevention, harm reduction, treatment, and recovery support services for opioid use disorder (OUD) and other substance use disorders (SUD).

The Oregon Health Authority (OHA) contracted with Portland State University (PSU) to conduct an impact evaluation of SOR2. As part of the evaluation, PSU conducted a sub-study focused on MAT program implementation, and whether SOR2 funding expanded access to and utilization of MAT services in Oregon (complete findings are available in the full report: *State Opioid Response 2 Grant: Medication Assisted Treatment Expansion Evaluation**). This brief is a summary of implementation lessons learned and recommendations for future expansion of MAT services.

Portland State UNIVERSITY

Oregon Health Authority

* This report is available upon request from Kelsey Smith-Payne at OHA: kelsey.smithpayne@dhsoha.state.or.us

November 2022

Description of MAT Grantees

SOR2 funds were distributed to agencies providing MAT services in eight counties (see Figure 1). The seven agencies included in the evaluation were newly providing MAT or expanding MAT to new locations. As such, most locations had been providing MAT services for less than one year at the time of their first interview. Six agencies were office-based opioid treatment (OBOT) programs, which allow primary care or general care providers with an X waiver (created by the Drug Addiction Treatment Act, or DATA) to prescribe MAT medications (e.g., buprenorphine, buprenorphine/naloxone, naltrexone).[1] One agency was an opioid treatment program (OTP). OTPs integrate SUD treatment with various recovery support services and are certified to dispense methadone as well as buprenorphine.[2]

Most SOR2 expansion agencies adopted a MAT-first model, where clients receive medication as quickly as possible prior to lengthy assessments. Two agencies were bridge clinics, providing short-term services to increase speed of access to medications and then working to connect clients with long-term access. Agencies were located in a mix of rural and urban settings.

Data Collection

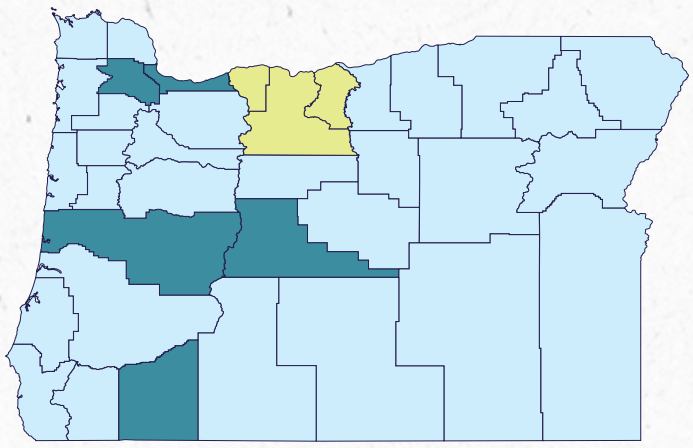
Data collection took place between June 2021 and July 2022. In consultation with OHA, PSU conducted two rounds of semi-structured interviews with MAT grantees to learn about their implementation successes and barriers, approach to health equity, and collaboration efforts. Among the seven agencies, 10 key staff participated in the first round, and 9 in the second round, of interviews.

Figure 1

Oregon counties with SOR2-funded grantees

Multnomah	Hood River*
Lane	Wasco*
Deschutes	Sherman*
Washington	
Jackson	

*New MAT service areas



1 Indian Health Services. (n.d.) *Office Based Opioid treatment* (*OBOT*). Retrieved from https://www.ihs.gov/opioids/recovery/obot/

2 Center for Substance Abuse Treatment. (2005). *Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs*. Treatment Improvement Protocol (TIP) Series 43. HHS Publication No. (SMA) 12-4214. Retrieved from: https://www.ncbi.nlm.nih.gov/books/NBK64168/

Implementation Lessons Learned

The information summarized here reflects grantees' experiences as they worked to implement MAT services and navigate healthcare system regulations and policies, as well as issues specific to their agencies. Although these grantees' experiences may not fully represent all agencies implementing MAT services in Oregon or in other geographical locations, their lessons learned can help support organizations as they begin implementing MAT services.

MAT implementation lessons learned are as follows:

Include key agency staff and diverse, knowledgeable informants in implementation planning. Implementation committees should include key agency staff; community partners, especially culturally-specific organizations working with communities most affected by OUD; and individuals with lived experience with SUD (i.e., peers). Additionally, establish early connections with other organizations providing MAT and seek guidance and planning support from expert consultants if possible.

Assess staff readiness to implement MAT and design strategies to improve buy-in. Some treatment providers have reservations about MAT. It might be necessary to promote organizational culture shifts from a drug-free orientation toward a harm reduction/MAT-first approach.

Assess community readiness for MAT services and design strategies to increase awareness and understanding. Community members and clients with OUD often have misconceptions about MAT. Community outreach efforts (e.g., distributing materials, meeting with community leaders, public service announcements) can help educate people about MAT and approaches to harm reduction. These efforts should be linguistically and culturally inclusive (e.g., materials translated into multiple languages, working with culturally-specific community organizations). Examine community OUD treatment needs and possible utilization rates, especially when looking to provide MAT in rural areas (i.e., larger catchment area with fewer people).

Develop infrastructure to support service provision and regulatory compliance. Update and create workflow protocols and practices to support staff in having a consistent approach to MAT service provision. It is important for agencies to align their internal processes with state and federal regulations and continuously monitor for compliance. Additionally, it is critical to collaborate with Coordinated Care Organizations (CCOs, which deliver care to Medicaid members) and private insurers to set up billing procedures that comply with their policies and regulations as soon as possible.

Develop data systems and an organizational culture that supports continuous quality improvement. A system for tracking and analyzing data is a critical part of quality improvement - it can illuminate gaps in service, barriers to access, and other aspects of service provision in need of improvement. An organizational culture that values learning, flexibility, and adaptation will help agencies improve conditions for employees, and promote equitable outcomes for clients and communities.

Integrate peer support services with MAT service provision. Peers can play a vital role in MAT service provision. Agencies should work to establish sustainable funding for the peer workforce and develop clear MAT-specific peer job descriptions. Once hired, agencies should provide MAT-specific training and support for peers, which will in turn enhance their ability to support clients.

Adapt MAT services to a telehealth model. Establish a telehealth (or hybrid) option for MAT services to create a low-barrier pathway to treatment. Telehealth can help address the shortage of prescribers, overcome geographical barriers, offer flexibility to clients, and provide long-term continuity of care. It is especially important to have protocols designed to meet confidentiality requirements for telehealth appointments.

Plan for staffing shortages. Anticipate and develop strategies for managing staffing challenges, including a shortage of X waivered providers, pay discrepancies, and credentialing requirements. Strategies will likely need to address internal policies (e.g., restrictive policies that make it difficult to hire peers), upskill existing staff, manage state and federal regulations (e.g., credentialing requirements), and be proactive (e.g., create a talent pipeline by partnering with local community colleges).

Recommendations

Based on findings from the SOR2 MAT Evaluation, we offer the following recommendations to support the future expansion of MAT services in Oregon:

Allocate more resources for implementation. Implementing MAT services requires funding, staff time, technical assistance, and infrastructure investments (e.g., data systems). Future expansion efforts should allocate a proportion of funding specifically for implementation, and support agencies in connecting with technical assistance, expert consultants, and learning communities with other MAT providers. A longer grant funding period would also provide more time and resources for implementation. The two-year SOR2 funding period essentially required agencies to fully implement MAT services without time for thorough planning and installation.

Continue funding work in priority populations. Intentionally identifying and funding services for priority populations can promote equitable access to services. SOR2 funding, for example, intentionally expanded access to MAT services in rural communities. Future funding could use the same approach to expand access to other populations experiencing the disproportionate impact of OUD. Funding should also incentivize agencies to adopt and strive toward goals for providing equitable access to MAT services. Last, fund culturally-specific organizations to create more opportunities for culturally- and linguistically-relevant MAT services and promote health equity.

Encourage agencies to involve people with lived experience. In alignment with SAMHSA's *Participation Guidelines for Individuals with Lived Experience* and Family, encourage agencies to involve peers/people with lived experience in designing their programs, including client outreach, engagement, and retention.[3] Agencies should also be incentivized to collect client feedback on their experiences with MAT services to better assess whether they are culturally-responsive, trauma-informed, and client-centered, and to identify areas for improvement.

Invest in the SUD workforce. Hiring and retaining high quality staff was one of the main challenges grantees faced. State and federal investments in the SUD workforce could help increase wages, expand training opportunities, increase the number of credentialed providers, and develop a career ladder in the field (e.g., support paid internships for CADC-Rs). Removing financial barriers (e.g., scholarship programs) would encourage more people to enter the SUD field, and offering financial incentives for priority provider populations (e.g., Spanish-speaking) would create more equitable workforce opportunities. Importantly, workforce efforts should also focus on removing barriers to accessing higher education that disproportionately affect certain communities (e.g., ethnic/racial minority groups, low-income students),[4,5,6] resulting in a less culturally and linguistically diverse healthcare workforce.

Support grantees' understanding of state and federal policies and advocate for any needed changes. As MAT expands across Oregon, it will be important for agencies to fully understand and navigate state and federal policies pertaining to MAT service provision. Some examples of regulations that grantees found challenging to navigate or would like to see changed are the Suboxone certification process, MAT location restrictions, and rules that do not allow methadone admissions over telehealth (for OTPs). Additional support developing cost calculators, negotiating fees with CCOs and private insurance providers, and finding ways to get reimbursed for outreach activities would support agencies' financial sustainability. Another area for advocacy is credentialing, which can place limits on who can provide services (e.g., restrictive background checks for peers) and create gaps in funding if there is staff turnover (e.g., processing time when CCO's credential providers).

Acknowledgement

We would like to thank the program staff who work each day to provide life-saving MAT services. We appreciate the time you spent sharing your experiences with us for this evaluation.

3 Substance Abuse and Mental Health Services Administration (SAMHSA). (2021). *Participation Guidelines for People with Lived Experience and Family*, Retrieved from https://www.samhsa.gov/grants/applying/guidelines-lived-experience

4 I., Safdar, B., Kaliamurthy, S., & Khosa, F. (2022). Gender and racial disparity among addiction psychiatry fellows in the United States. *Psychiatric Quarterly*, *93*(2), 547–558. https://doi.org/10.1007/s11126-021-09970-3

5 Wyse, R., Hwang, W.-T., Ahmed, A. A., Richards, E., & Deville, C. (2020). Diversity by race, ethnicity, and sex within the US Psychiatry Physician Workforce. *Academic Psychiatry, 44*(5), 523–530. https://doi.org/10.1007/s40596-020-01276-z

6 Iglehart, J. K. (2014). Diversity dynamics — challenges to a representative U.S. medical workforce. *New England Journal of Medicine, 371*(16), 1471–1474. https://doi.org/10.1056/nejmp1408647

Appendix E: ETC Follow Up Survey

Introduction and Consent

Thank you for your participation in Education Toward CADC (ETC) and your interest in this follow-up survey!

Share your experiences and receive a $20 gift card!

Portland State University (PSU) is partnering with the Oregon Health Authority (OHA) to learn about how Education Toward CADC (ETC) helps support Oregon's behavioral health workforce. This survey is part of a larger evaluation of Oregon's State Opioid Response (SOR) grant.

Before completing the survey, here are some things you should know:

- We anticipate the survey will take 15-20 minutes.
- **Your participation is voluntary.** You may stop completing the survey at any time. You may choose not to answer questions. Stopping the survey will not affect your job or any professional development activities you may pursue.
- **Your responses are confidential.** Any information we share with the OHA will not include names, positions, or other ways to identify you. Your responses will not be linked to your personal information. The information collected will only be used for this study.
- Findings from this survey will be provided to you in a brief survey report.
- If you have any questions, please contact Nicole Lauzus at PSU (nlauzus@pdx.edu; 503-725-9842).

Portland State University

Oregon Health Authority

Statement of Risks/Benefits

- This study has no major risks. However, you might feel uncomfortable with some of the topics. If so, you can choose not to answer a question or quit the survey. It is also possible that information could be seen by people outside the project. To protect against this risk, we will not link your name to your responses. We also keep all information secure in password protected files.

- You will help leaders at OHA understand how trainings like the ETC support Oregon's behavioral health workforce.
- At the end of the survey, PSU will send you a $20 Amazon e-gift card to the email address you provide. Gift cards can be sent to a physical address upon request. Your email (or physical) address will not be associated with your responses and will not be used for any other purpose.

Participant Statement

I have read this consent form, and I understand what it says. I understand that the information I share will only be used for this study. I understand that PSU will do all they can to keep this information private. I understand by completing this survey, I consent for PSU to use the information I share for this study.

Click the right arrow below to start the survey.

Employment Questions

Were you already employed when you signed up for the Education Toward CADC (ETC) program?

- ◯ Yes
- ◯ No

Are you currently employed?

- ◯ Yes
- ◯ No

Which best describes your current role? Please select all that apply:

- ☐ SUD Counselor
- ☐ SUD Peer
- ☐ SUD Case manager
- ☐ Doctor
- ☐ Nurse
- ☐ Administrative Staff
- ☐ Other, please describe:
- ☐ Not applicable/Not employed

How long have you worked for your current employer (in years)? If unemployed, please enter 0.

Do you work full-time or part time?

- ◯ Full-time
- ◯ Part-time
- ◯ On-call/consultation
- ◯ Not applicable/Not employed

Are you content with that status?

- ◯ No
- ◯ Yes
- ◯ Indifferent
- ◯ Not applicable/Not employed

How likely are you to remain in your current role for the next year?

- ◯ Very Likely
- ◯ Somewhat Likely
- ◯ Undecided
- ◯ Somewhat Unlikely
- ◯ Very Unlikely
- ◯ Not applicable/Not employed

Why are you Undecided, Somewhat Unlikely, or Very Unlikely to remain in your current role for the next year? Please select all that apply.

- ☐ Promotion
- ☐ New role in same agency
- ☐ Similar role at different agency
- ☐ Career change
- ☐ Retirement
- ☐ Inadequate wages
- ☐ Inadequate benefits
- ☐ Not enough hours/FTE
- ☐ Lack of employer support
- ☐ Physical health
- ☐ Mental health

- [ ] Burnout
- [ ] Pending lay off
- [ ] COVID-19, please specify:
- [ ] Family responsibilities (e.g., child care)
- [ ] Other, please describe:

Do you want to be employed in the substance use disorder/behavioral health field?

- ◯ No
- ◯ Yes

How much employment are you seeking?

- ◯ Full-time
- ◯ Part-time
- ◯ On-call/consultation
- ◯ Any of the above

What are the barriers to finding employment? Please select all that apply.

- [ ] Insufficient wage
- [ ] Insufficient benefits
- [ ] Schedule
- [ ] COVID-19, please specify:
- [ ] Family responsibilities (e.g., child care)
- [ ] Lack of job openings
- [ ] Commute/travel requirements
- [ ] Other, please describe:

CADC Education Questions

Why did you participate in the ETC program? Please select all that apply.

- [ ] Required by employer
- [ ] Increase skills/better serve clients
- [ ] Higher pay

- [ ] Dual credential
- [ ] Better opportunities within agency
- [ ] New challenge
- [ ] Career goals
- [ ] Improve credentials
- [ ] Change career path
- [ ] Other, please describe:

How has the ETC program changed your work practices?

Have you received the CADC I certification?

- ◯ No
- ◯ Yes

Were you required to pay a fee to register for the CADC certification (CADC-r)?

- ◯ No
- ◯ Yes
- ◯ Not applicable/Not registered for CADC certification

Do you have any concerns about maintaining the continuing education requirement for CADC I certification?

- ◯ Yes, please describe:
- ◯ No
- ◯ Not applicable/No plans for CADC I certification

What are the reason(s) you do not have the CADC I at this time? Please select all that apply.

- [ ] Need supervised experience hours in addictions counseling
- [ ] Difficulty connecting with a Clinical Supervisor with the appropriate credentials to verify your experience hours
- [ ] Have not taken the certification exam
- [ ] Unable to afford the certification exam

- [ ] Certification exam is not offered in my preferred language
- [ ] Have not passed the certification exam
- [ ] Did not or would not clear the criminal background check
- [ ] No plans for certification
- [ ] Other, please describe:

How many more supervised experience hours do you estimate needing?

- ◯ Less than half
- ◯ Half
- ◯ More than half
- ◯ Unknown

Are you employed somewhere you can get supervised experience hours?

- ◯ Yes
- ◯ No
- ◯ N/A - not currently employed

Is there a Clinical Supervisor with the appropriate credentials to verify your experience hours where you work?

- ◯ Yes
- ◯ No
- ◯ N/A - not currently employed

Is there anything else you want to share about your ability to secure a Clinical Supervisor to verify your experience hours?

How would you describe your employment plans for the next year? Please select all that apply.

- [ ] Maintain current employment
- [ ] Increase practice/work hours
- [ ] Reduce practice/work hours
- [ ] Move practice out of state
- [ ] Go back to school
- [ ] Retire
- [ ] Leave social service field
- [ ] Move to a different area of the social service field

- [ ] Advance in behavior health/SUD
- [ ] Return to behavioral health/SUD position (if currently unemployed or employed outside of behavioral health/SUD)
- [ ] Other, please describe:

Is there anything else you think we should know about the impact of the Education Toward CADC (ETC) program?

Demographics

We are asking the following questions about your background to learn more about the providers who decided to participate in this survey about the Education Toward CADC program. The PSU team will keep this information confidential.

How would you describe your gender?

- ◯ Female
- ◯ Male
- ◯ Nonbinary
- ◯ Other, please describe:
- ◯ Prefer not to answer

Which of the following racial or ethnic groups best describe your background? Please select all that apply.

- [ ] African American or Black
- [ ] American Indian or Alaska Native
- [ ] Asian
- [ ] Hispanic/Latinx
- [ ] Middle Eastern/North African
- [ ] White
- [ ] Other, please describe:
- [ ] Don't know/prefer not to answer

What language(s) do you typically speak at home? Please select all that apply.

- [ ] Chinese

- [ ] English
- [ ] Russian
- [ ] Spanish
- [ ] Vietnamese
- [ ] Other, please specify:
- [ ] Prefer not to answer

Please select the area(s) in Oregon where you currently work, or if unemployed, hope to work:

[ ] Baker	[ ] Douglas	[ ] Lake	[ ] Sherman
[ ] Benton	[ ] Gilliam	[ ] Lane	[ ] Tillamook
[ ] Clackamas	[ ] Grant	[ ] Lincoln	[ ] Umatilla
[ ] Clatsop	[ ] Harney	[ ] Linn	[ ] Union
[ ] Columbia	[ ] Hood River	[ ] Malheur	[ ] Wallowa
[ ] Coos	[ ] Jackson	[ ] Marion	[ ] Wasco
[ ] Crook	[ ] Jefferson	[ ] Morrow	[ ] Washington
[ ] Curry	[ ] Josephine	[ ] Multnomah	[ ] Wheeler
[ ] Deschutes	[ ] Klamath	[ ] Polk	[ ] Yamhill

In order to learn if participants are from frontier, rural, or urban areas, please tell us the zip code where you live. Your information will not be shared or used for any other reason.

What is the highest level of education you have attained?

- ◯ High school/GED
- ◯ Associate degree
- ◯ Bachelor's degree
- ◯ Graduate degree, please specify:
- ◯ Other, please describe:

Gift card information

We are collecting the following information to send you a gift card. Your information will remain confidential, and will not be shared.

What is your name?

May we send an electronic gift card to your email address?

- ◯ Yes, please provide your email address:
- ◯ No, please provide physical address for gift card:
  Note: please allow 4-6 business weeks to receive mailed gift card
- ◯ I do not want to receive a gift card

Appendix F: Core Peer Training Follow Up Survey

Employment

Thank you for your participation in Core Peer Training and your interest in this follow-up survey!

Si desea realizar la encuesta en español, haga clic aquí.

Share your experiences and receive a $30 gift card!

Portland State University (PSU) is partnering with the Oregon Health Authority (OHA) to learn about how Core Peer Training helps support Oregon's behavioral health workforce. This survey is part of a larger evaluation of Oregon's State Opioid Response (SOR) grant.

Before completing the survey, here are some things you should know:

- We anticipate the survey will take 15-20 minutes.
- **Your participation is voluntary.** You may stop completing the survey at any time. You may choose not to answer questions. Stopping the survey will not affect your job or any professional development activities you may pursue.
- **Your responses are confidential.** Any information we share with the OHA will not include names, positions, or other ways to identify you. Your responses will not be linked to your personal information. The information collected will only be used for this study.
- Findings from this survey will be provided to you in a brief survey report.
- If you have any questions, please contact Nicole Lauzus at PSU (nlauzus@pdx.edu; 503-725-9842).

Oregon Health Authority

Portland State University

Statement of Risks/Benefits

- This study has no major risks. However, you might feel uncomfortable with some of the topics. If so, you can choose not to answer a question or quit the survey. It is also possible that information could be seen by people outside the project. To protect against this risk, we will not link your name to your responses. We also keep all information secure in password protected files.
- You will help leaders at OHA understand how trainings like the Core Peer Training support Oregon's behavioral health workforce.
- At the end of the survey, PSU will send you a $30 Amazon e-gift card to the email address you provide. Gift cards can be sent to a physical address upon request. Your email (or physical) address will not be associated with your responses and will not be used for any other purpose.

Participant Statement

I have read this consent form, and I understand what it says. I understand that the information I share will only be used for this study. I understand that PSU will do all they can to keep this information private. I understand by completing this survey, I consent for PSU to use the information I share for this study.

Click the right arrow below to start the survey.

When did you participate in the 40-hour Core Peer Training?

Why did you participate in the Core Peer Training? Please select all that apply.

- [ ] Required by employer
- [ ] Required for certification
- [ ] Required for recertification
- [ ] Increase skills/better serve clients
- [ ] Higher pay
- [ ] Better opportunities within agency
- [ ] Career goals
- [ ] Improve credentials
- [ ] Change in career path
- [ ] New challenge
- [ ] Other, please describe:

How has the Core Peer Training changed your work practices?

We're interested in learning about the credentials, certifications, etc. that you earned or are working towards. Please enter a response for each of the following credentials:

	I had this credential **prior to** the Core Peer Training	I earned this credential **after** the Core Peer Training	I am currently working towards this credential	I'm interested in this credential but have not taken steps to attain it yet	I do not have plans to attain this credential
Certified Recovery Mentor (CRM)	☐	☐	☐	☐	☐
Peer Support Specialist (PSS)	☐	☐	☐	☐	☐
Peer Wellness Specialist (PWS)	☐	☐	☐	☐	☐
Qualified Mental Health Associate (QMHA)	☐	☐	☐	☐	☐
Qualified Mental Health Professional (QMHP)	☐	☐	☐	☐	☐
Licensed Clinical Social Worker (LCSW)	☐	☐	☐	☐	☐

	I had this credential **prior to** the Core Peer Training	I earned this credential **after** the Core Peer Training	I am currently working towards this credential	I'm interested in this credential but have not taken steps to attain it yet	I do not have plans to attain this credential
Licensed Marriage and Family Therapist (LMFT)	☐	☐	☐	☐	☐
Certified Alcohol and Drug Counselor (CADC)	☐	☐	☐	☐	☐
Other, please describe:	☐	☐	☐	☐	☐
Other, please describe:	☐	☐	☐	☐	☐
Other, please describe:	☐	☐	☐	☐	☐

Have you experienced any challenges earning a certification? Please select all that apply.

- ☐ No challenges with certification
- ☐ Unable to afford the application/certification fee (visit MHACBO for more information about certifications such as CRM or CADC and any available fee waivers.)
- ☐ Did not or would not clear the criminal background check
- ☐ Need two years of recovery
- ☐ Need Oral Health Training
- ☐ Other, please describe:
- ☐ No plans for certification

Many certifications (such as CRM or PSS) have continuing education requirements for recertification. Do you have any concerns about maintaining the continuing education requirement for recertification? Please select all that apply.

- ☐ No concerns
- ☐ Time required for continuing education opportunities
- ☐ Cost of continuing education opportunities
- ☐ Availability of continuing education opportunities
- ☐ Lack of opportunities that are relevant to my area of interest
- ☐ Lack of culturally relevant opportunities
- ☐ Other, please describe:
- ☐ No plans for certification

Is there anything else you want to share about certification? (process, requirements, etc.)

Were you aware of the Certified Recovery Mentor II certification? If you are interested, more information can be found on the MHACBO website.

- ◯ Yes
- ◯ No
- ◯ Unsure

Are you currently employed?

- ◯ Yes
- ◯ No

What is your role:

- ◯ SUD Counselor
- ◯ SUD Peer
- ◯ SUD Case manager
- ◯ Doctor
- ◯ Nurse
- ◯ Administrative staff
- ◯ Other, please describe:
- ◯ Not applicable/Not employed

How long (in years) have you been employed with the current organization? If unemployed, please enter 0.

How long (in years) have you been employed in your current role? If unemployed, please enter 0.

Do you work full-time or part-time?

- ◯ Full-time
- ◯ Part-time
- ◯ On-call/consultation

- ◯ Not applicable/Not employed

Are you content with that status?

- ◯ Yes
- ◯ No
- ◯ Indifferent
- ◯ Not applicable/Not employed

How likely are you to remain in your current job for the next year?

- ◯ Very Likely
- ◯ Somewhat Likely
- ◯ Undecided
- ◯ Somewhat Unlikely
- ◯ Very unlikely
- ◯ Not applicable/Not employed

Why are you undecided, somewhat unlikely, or very unlikely to remain in your current job for the next year? Please select all that apply.

- ☐ Promotion
- ☐ New role in same agency
- ☐ Similar role at different agency
- ☐ Career change
- ☐ Retirement
- ☐ Inadequate wages
- ☐ Inadequate benefits
- ☐ Not enough hours/FTE
- ☐ Lack of employer support
- ☐ Physical health
- ☐ Mental health
- ☐ Burnout
- ☐ Pending lay off
- ☐ Covid-19, please describe:
- ☐ Family responsibilities (e.g., child care)
- ☐ Other, please describe:

Do you want to be employed in the substance use disorder/behavioral health field?

- ◯ Yes
- ◯ No

How much employment are you seeking?

- ◯ Full-time
- ◯ Part-time
- ◯ On-call/consultation
- ◯ Any of the above

What are the barriers to finding employment? Please select all that apply.

- ☐ Inadequate wages
- ☐ Inadequate benefits
- ☐ Schedule
- ☐ Covid-19, please describe:
- ☐ Family responsibilities (e.g., child care)
- ☐ Lack of job openings
- ☐ Commute/travel requirements
- ☐ Searching/interviewing but no offers
- ☐ Other, please describe:O

Training Questions

How would you describe your employment plans for the next year? Please select all that apply.

- ☐ Maintain current employment
- ☐ Increase work hours
- ☐ Reduce work hours
- ☐ Move employment out of state
- ☐ Go back to school
- ☐ Retire
- ☐ Leave social service field
- ☐ Move to a different area of the social service field
- ☐ Advance in behavioral health/SUD
- ☐ Return to behavioral health/SUD position (if currently unemployed or employed outside of behavioral health/SUD)

- [ ] Other, please describe:

Is there anything else you think we should know about your experience with the Core Peer Training or the influence of the Core Peer Training on your career?

Demographics

We are asking the following questions about your background to learn more about the providers who decided to participate in this survey about the Core Peer Training program. The PSU team will keep this information confidential.

How would you describe your gender?

- ◯ Female
- ◯ Male
- ◯ Non-binary / third gender
- ◯ Two-spirit
- ◯ Not listed, please describe:
- ◯ Prefer not to say

Which of the following racial or ethnic groups best describe your background? Please select all that apply.

- [ ] African American or Black
- [ ] American Indian or Alaska Native
- [ ] Asian
- [ ] Hispanic or Latinx
- [ ] Middle Eastern or North African
- [ ] Native Hawaiian or Pacific Islander
- [ ] White
- [ ] Not listed, please describe:
- [ ] Don’t know/prefer not to answer

What language(s) do you typically speak at home? Please select all that apply.

- [ ] Chinese
- [ ] English
- [ ] Russian
- [ ] Spanish
- [ ] Vietnamese
- [ ] Not listed, please describe:
- [ ] Prefer not to answer

Please select the county/ies in Oregon where you currently work or, if unemployed, hope to work:

[ ] Baker	[ ] Douglas	[ ] Lake	[ ] Sherman
[ ] Benton	[ ] Gilliam	[ ] Lane	[ ] Tillamook
[ ] Clackamas	[ ] Grant	[ ] Lincoln	[ ] Umatilla
[ ] Clatsop	[ ] Harney	[ ] Linn	[ ] Union
[ ] Columbia	[ ] Hood River	[ ] Malheur	[ ] Wallowa
[ ] Coos	[ ] Jackson	[ ] Marion	[ ] Wasco
[ ] Crook	[ ] Jefferson	[ ] Morrow	[ ] Washington
[ ] Curry	[ ] Josephine	[ ] Multnomah	[ ] Wheeler
[ ] Deschutes	[ ] Klamath	[ ] Polk	[ ] Yamhill

In order to learn if participants are from frontier, rural, or urban areas, please tell us the zip code where you live. Your zip code will not be used for any other reason.

What is the highest level of education you have attained?

- ◯ Some high school
- ◯ High school/GED
- ◯ Trade school
- ◯ Associate degree
- ◯ Bachelor's degree
- ◯ Graduate degree, please specify:
- ◯ Other, please describe:

Gift card

We are collecting the following information to send you a gift card. Your information will remain confidential, and will not be shared.

What is your name?

May we send an electronic gift card to your email address?

- ◯ Yes, my email address is:
- ◯ No, please send a physical gift card to my address at:

  Note: please allow 4-6 business weeks for a mailed gift card to arrive.
- ◯ No, I do not want a gift card

Appendix G: Encuesta de seguimiento de la capacitación básica entre pares

Employment

¡Gracias por su participación en la capacitación básica entre pares y por su interés en esta encuesta de seguimiento!

If you prefer to take the survey in English, click here.

¡Comparta su experiencia y obtenga una tarjeta de regalo de $30!

La Universidad Estatal de Portland (PSU) se ha asociado en colaboración con la Autoridad de Salud de Oregón (Oregon Health Authority, OHA) para conocer más acerca de cómo la capacitación básica entre pares ayuda a contribuir con el personal de salud del comportamiento de Oregón. Esta encuesta es parte de una evaluación más amplia del subsidio destinado a la Respuesta estatal a los opiáceos (State Opioid Response, SOR) de Oregón.

Antes de responder la encuesta, estas son algunas cosas que debería saber

- Prevemos que responder la encuesta le llevará de 15 a 20 minutos.
- **Su participación es voluntaria.** Puede dejar de responder la encuesta en cualquier momento. Puede elegir no contestar las preguntas. La interrupción de la encuesta no afectará su trabajo ni ninguna actividad de desarrollo profesional a la que pueda dedicarse.
- **Sus respuestas son confidenciales.** Cualquier tipo de información que compartamos con la Autoridad de Salud de Oregon (OHA) no incluirá nombres, puestos ni otras maneras de identificarlo. Sus respuestas no estarán relacionadas con su información personal. La información recopilada se utilizará solamente para este estudio.
- Se le ofrecerán los hallazgos derivados de esta encuesta en un informe breve de la encuesta.
- Si tiene alguna pregunta, por favor comuníquese con Nicole Lauzus en la Universidad Estatal de Portland (PSU) (nlauzus@pdx.edu; 503-725-9842).

Oregon Health Authority

Portland State UNIVERSITY

Declaración de riesgos/beneficios

- Este estudio no tiene ningún riesgo importante. Sin embargo, podría sentirse incómodo con algunos de los temas. De ser así, puede optar por no responder una pregunta o abandonar la encuesta. También es posible que personas ajenas al proyecto puedan ver la información. Para protegernos contra este riesgo, no relacionaremos su nombre con sus respuestas. Además, almacenamos toda la información de forma segura en archivos protegidos por contraseña.
- Usted colaborará con líderes de la Autoridad de Salud de Oregón (OHA) a comprender de qué manera las capacitaciones, tales como la capacitación básica entre pares, contribuye con el personal de salud del comportamiento de Oregón.
- Al final de la encuesta, la Universidad Estatal de Oregón (PSU) le enviará una tarjeta electrónica de regalo de Amazon de $30 a la dirección de correo electrónico que usted brinde. Las tarjetas de regalo pueden enviarse a una dirección física a pedido. Sus datos de dirección de correo electrónico (o de su dirección postal) no se relacionarán con sus respuestas ni tampoco se utilizarán para ningún otro fin.

Declaración del/de la participante
He leído este formulario de consentimiento y entiendo lo que establece. Entiendo que la información que comparta solamente se usará para este estudio. Entiendo que la Universidad Estatal de Oregón (PSU) hará todo lo posible por proteger la privacidad de esta información. Entiendo que, al responder esta encuesta, le otorgo mi consentimiento a PSU para usar la información que comparta para este estudio.

Para comenzar la encuesta, haga clic en la flecha hacia la derecha que aparece a continuación.

¿Cuando participó en el Core Peer Training de 40 horas?

¿Por qué participó en la capacitación básica entre pares? Seleccione todas las opciones que correspondan.

- [ ] Requerido por el empleador
- [ ] Requerido para la certificación
- [ ] Requerido para la recertificación
- [ ] Aprender habilidades/brindar un mejor servicio a los clientes
- [ ] Mayor remuneración
- [ ] Mejores oportunidades dentro de la agencia
- [ ] Metas profesionales
- [ ] Mejorar credenciales
- [ ] Cambio en la trayectoria de su carrera profesional
- [ ] Nuevo desafío
- [ ] Otro, describa:

¿De qué manera la capacitación básica entre pares cambió sus prácticas laborales?

Estamos interesados en conocer las credenciales, las certificaciones, etc. que haya obtenido o que procura obtener. Ingrese una respuesta para cada una de las siguientes credenciales.

	Tenía esta credencial **antes de** la capacitación básica entre pares	Obtuve esta credencial **después de** la capacitación básica entre pares	Actualmente, estoy trabajando para obtener esta credencial	Me interesa esta credencial, pero aún no he hecho ningún paso para obtenerla	No tengo planes de obtener esta credencial
Mentor de recuperación certificado (CRM)	☐	☐	☐	☐	☐
Especialista en apoyo de pares (PSS)	☐	☐	☐	☐	☐

	Tenía esta credencial **antes de** la capacitación básica entre pares	Obtuve esta credencial **después de** la capacitación básica entre pares	Actualmente, estoy trabajando para obtener esta credencial	Me interesa esta credencial, pero aún no he hecho ningún paso para obtenerla	No tengo planes de obtener esta credencial
Especialista en bienestar de pares (PWS)	☐	☐	☐	☐	☐
Asociado de salud mental calificado (QMHA)	☐	☐	☐	☐	☐
Profesional de salud mental calificado (QMHP)	☐	☐	☐	☐	☐
Trabajador social clínico con licencia (LCSW)	☐	☐	☐	☐	☐
Terapeuta familiar y matrimonial con licencia (LMFT)	☐	☐	☐	☐	☐
Consejero certificado en alcoholismo y drogadicción (CADC)	☐	☐	☐	☐	☐
Otro, describa:	☐	☐	☐	☐	☐
Otro, describa:	☐	☐	☐	☐	☐
Otro, describa:	☐	☐	☐	☐	☐

¿Ha tenido algún inconveniente para obtener esta certificación? Seleccione todas las opciones que correspondan.

- ☐ Ningún inconveniente con la certificación
- ☐ No puedo afrontar el costo para presentar la solicitud/certificación (Comuníquese con MHACBO para obtener más información sobre las certificaciones como CRM o CADC y cualquier exención del costo disponible)
- ☐ No pasé o no pasaría la verificación de antecedentes penales
- ☐ Necesito dos años de recuperación
- ☐ Necesito capacitación sobre salud bucal
- ☐ Otro, describa:
- ☐ No tengo planes de obtener una certificación

Muchas certificaciones (como CRM o PSS) tienen requisitos de educación continua para la recertificación. ¿Tiene alguna inquietud con respecto a cumplir con el requisito de educación continua para la recertificación?

- ☐ Ninguna inquietud
- ☐ El tiempo requerido para las oportunidades de educación continua
- ☐ El costo de las oportunidades de educación continua
- ☐ La disponibilidad de oportunidades de educación continua

- [ ] La falta de oportunidades que son relevantes para mi área de interés
- [ ] La falta de oportunidades culturalmente relevantes
- [ ] Otro, describa:
- [ ] No tengo planes de obtener una certificación

¿Hay algo más que quisiera compartir sobre la certificación (proceso, requisitos, etc.)?

¿Estaba al tanto de la certificación Mentor de recuperación certificado II? Si está interesado, puede encontrar más información en el sitio web de MHACBO.

- ◯ Sí
- ◯ No
- ◯ No estoy seguro/a

Actualmente, ¿tiene empleo?

- ◯ Sí
- ◯ No

¿Cuál es su función?

- ◯ Consejero de trastornos por abuso de sustancias (SUD)
- ◯ Par para la recuperación de SUD
- ◯ Coordinador de casos de SUD
- ◯ Médico/a
- ◯ Enfermero/a
- ◯ Personal administrativo
- ◯ Otro, describa:
- ◯ No aplicable/No tengo empleo

¿Durante cuánto tiempo (en años) ha trabajado en la organización actual? Si no tiene un empleo, ingrese 0.
Nota: por favor ingrese un número válido

¿Durante cuánto tiempo (en años) ha trabajado en su función actual? Si no tiene un empleo, ingrese 0.
Nota: por favor ingrese un número válido

¿Tiene trabajo de tiempo completo o de medio tiempo?

- ◯ Tiempo completo
- ◯ Medio tiempo
- ◯ De guardia/por consulta
- ◯ No aplicable/No tengo empleo

¿Está conforme con esa condición de empleo?

- ◯ Sí
- ◯ No
- ◯ Indiferente
- ◯ No aplicable/No tengo empleo

¿Qué tan probable es que siga en su trabajo actual el próximo año?

- ◯ Muy probable
- ◯ Algo probable
- ◯ Indeciso/a
- ◯ Algo improbable
- ◯ Muy improbable
- ◯ No aplicable/No tengo empleo

¿Por qué no está decidido, es algo improbable o muy improbable que siga en su trabajo actual el próximo año? Seleccione todas las opciones que correspondan.

- ☐ Ascenso
- ☐ Nuevo puesto en la misma agencia
- ☐ Puesto similar en una agencia diferente
- ☐ Cambio de carrera profesional
- ☐ Jubilación
- ☐ Salarios inadecuados
- ☐ Beneficios inadecuados
- ☐ Cantidad insuficiente de horas/Equivalente a tiempo completo
- ☐ Falta de apoyo por parte del empleador
- ☐ Salud física

- [ ] Salud mental
- [ ] Agotamiento
- [ ] Despido pendiente
- [ ] COVID-19, describa:
- [ ] Responsabilidades familiares (p. ej., cuidado de niños)
- [ ] Otro, describa:

¿Quiere tener un empleo en el campo de trastornos por abuso de sustancias/salud del comportamiento?

- ◯ Sí
- ◯ No

¿Cuánto tiempo quiere trabajar?

- ◯ Tiempo completo
- ◯ Medio tiempo
- ◯ De guardia/por consulta
- ◯ Ninguna de las opciones anteriores

¿Cuáles son los obstáculos para encontrar un empleo? Seleccione todas las opciones que correspondan.

- [ ] Salarios inadecuados
- [ ] Beneficios inadecuados
- [ ] Horarios
- [ ] COVID-19, describa:
- [ ] Responsabilidades familiares (p. ej., cuidado de niños)
- [ ] Falta de vacantes
- [ ] Requisitos de traslados/viaje para trabajar
- [ ] Búsquedas/entrevistas, pero ninguna oferta
- [ ] Otro, describa:

Training Questions

¿Cómo describiría sus planes de empleo para el próximo año? Seleccione todas las opciones que correspondan.

- [ ] Mantener el empleo actual

- [ ] Aumentar las horas de trabajo
- [ ] Reducir las horas de trabajo
- [ ] Traspaso a un empleo fuera del estado
- [ ] Volver a estudiar
- [ ] Jubilarme
- [ ] Abandonar el campo de los servicios sociales
- [ ] Pasar a un área diferente del campo de servicios sociales
- [ ] Avanzar en el área de salud del comportamiento/SUD
- [ ] Regresar al puesto en el área de salud del comportamiento/SUD (si actualmente no tiene un empleo o no trabaja en el área de salud del comportamiento/SUD)
- [ ] Otro, describa:

¿Hay algo más que considera que deberíamos saber sobre su experiencia con la capacitación básica entre pares o sobre la influencia de la capacitación básica entre pares en su carrera profesional?

Demographics

Hacemos las siguientes preguntas sobre su información personal para conocer más sobre los proveedores que decidieron participar en esta encuesta sobre el programa de capacitación básica entre pares. El equipo de PSU mantendrá la confidencialidad de esta información.

¿Cómo describiría su género?

- ◯ Mujer
- ◯ Masculino
- ◯ No binario/tercer género
- ◯ Dos espíritus
- ◯ No indicado, describa:
- ◯ Prefiero no responder

¿Cuál de los siguientes grupos raciales o étnicos describe mejor sus antecedentes? Seleccione todas las opciones que correspondan.

- [ ] Negro o afroestadounidense
- [ ] Indígena estadounidense o nativo de Alaska
- [ ] Asiático
- [ ] Hispano o latinx
- [ ] De Medio Oriente o África del Norte
- [ ] Nativo de Hawái o de las Islas del Pacífico
- [ ] Blanco
- [ ] No indicado, describa:
- [ ] No sé/Prefiero no responder

¿Qué idioma(s) habla generalmente en su hogar? Seleccione todas las opciones que correspondan.

- [ ] Chino
- [ ] Inglés
- [ ] Ruso
- [ ] Español
- [ ] Vietnamita
- [ ] No indicado, describa:
- [ ] Prefiero no responder

Seleccione el o los condados de Oregón en los que trabaja actualmente o, si está desempleado, en los que espera trabajar:

[ ] Baker	[ ] Douglas	[ ] Lake	[ ] Sherman
[ ] Benton	[ ] Gilliam	[ ] Lane	[ ] Tillamook
[ ] Clackamas	[ ] Grant	[ ] Lincoln	[ ] Umatilla
[ ] Clatsop	[ ] Harney	[ ] Linn	[ ] Union
[ ] Columbia	[ ] Hood River	[ ] Malheur	[ ] Wallowa
[ ] Coos	[ ] Jackson	[ ] Marion	[ ] Wasco
[ ] Crook	[ ] Jefferson	[ ] Morrow	[ ] Washington
[ ] Curry	[ ] Josephine	[ ] Multnomah	[ ] Wheeler
[ ] Deschutes	[ ] Klamath	[ ] Polk	[ ] Yamhill

A fin de saber si los participantes son de áreas fronterizas, rurales o urbanas, incluya el código postal del área donde vive. Su código postal no se utilizará por ningún otro motivo.

¿Cuál es el nivel más alto de educación que ha completado?

- ◯ Parte de la escuela preparatoria
- ◯ Escuela preparatoria/Desarrollo Educativo General (GED)
- ◯ Escuela de oficios
- ◯ Técnico superior universitario
- ◯ Título de primer grado universitario
- ◯ Título de posgrado, especifique:
- ◯ Otro, describa:

Gift card

Estamos recopilando la siguiente información para enviarle una tarjeta de regalo. Su información seguirá siendo confidencial y no se compartirá.

¿Cuál es su nombre?

¿Podemos enviarle una tarjeta electrónica de regalo a su dirección de correo electrónico?

- ◯ Sí, mi dirección de correo electrónico es:
- ◯ No, envíeme una tarjeta de regalo a mi dirección postal a:

  Nota: una tarjeta de regalo enviada por correo postal puede demorar de 4 a 6 semanas hábiles en llegar.
- ◯ No, no quiero una tarjeta de regalo

Appendix H: Education Toward CADC Follow Up Survey Report

Education Toward CADC Follow Up Survey Report

AUTHORS

Nicole Lauzus

Carrie Furrer

Katie Shammel

Portland State University

For questions please contact:
Nicole Lauzus, nlauzus@pdx.edu

Introduction

The Oregon Health Authority (OHA) contracted with Portland State University (PSU) to conduct an impact evaluation of the second round of State Opioid Response funding (SOR2)[1]. Part of the evaluation examined the impact of SOR2 funding on Oregon's workforce providing substance use disorder (SUD) treatment and recovery services. Dr. Janis Crawford received SOR2 funds to expand Oregon's SUD workforce by increasing the number of Certified Alcohol and Drug Counselors (CADCs). Dr. Crawford developed a curriculum that fulfills the 150-hour education requirement for taking the CADC-I exam. The training, Education Toward CADC (ETC), and its books and materials are provided to participants at no cost. Once participants have completed the education requirement, they must accrue 1,000 supervised experience hours and pass a certification exam to earn their CADC-I credential.

OHA expresses a commitment to health equity in Oregon, achieved in part through the equitable distribution of resources. OHA identified rural and frontier communities, which are often under-resourced and face acute behavioral health workforce challenges, as a priority population for expanding access to SUD workforce development opportunities (Zhu et al., 2022). Through targeted recruitment in rural and frontier communities, Dr. Crawford and her team delivered ETC to two cohorts in 2021. This included a remote orientation held via Zoom followed by an in-person, 5-day retreat (as 40 hours of education are required to be in person for CADC certification), and then 16 all-day (Saturdays) courses on Zoom. The first cohort ran from June 12-October 23, 2021, and the second cohort took place from August 7–December 11, 2021. There were 40 participants who signed up for the ETC cohorts, and 32 people (80%) completed the program. PSU followed up with ETC participants to learn about how the ETC training influenced their career trajectories.

1 The SOR2 funding period was September 30, 2020 through September 30, 2022.

Evaluation Method

PSU created an online survey in collaboration with Dr. Crawford and OHA partners. The survey included questions about participants' motivations for pursuing the ETC program, progress towards a CADC credential, and their career plans since completing ETC. It also asked participants to share information about their background, including demographic data, education, and employment. PSU developed the brief (approximately 15-minute) survey using the Qualtrics survey platform, and it included multiple choice, rating scale, and open-ended questions.

Dr. Crawford compiled email addresses for the participants who completed ETC, and PSU distributed the survey and sent reminders. All survey respondents received a $20 Amazon e-gift card. The survey was sent to participants in each cohort approximately three months after the program concluded. The survey was distributed to the first ETC cohort in February 2022, and 13 of the 17 people from this cohort completed the survey. The survey was sent to the second ETC cohort in March 2022; 9 out of 15 people completed this survey. In total, 22 people (69%) completed the survey. PSU combined both cohorts for analysis, which included descriptive statistics and thematic analysis of qualitative responses.

Survey Findings

The findings reported in this section are based on 22 individuals who completed the survey. It includes their background and employment characteristics, reasons for attending the ETC program, and impact on their career trajectories. This section also includes a description of limitations to consider when interpreting these survey findings.

Background Characteristics

→ Most survey respondents identified as female and typically spoke English at home.

→ One-third of respondents identified as Hispanic/Latinx, American Indian/Alaskan Native, or Asian/Pacific Islander, and the remaining identified as white. This group represents greater diversity than rural/non-metro Oregon in general, where 2.4% identify as American Indian or Alaska Native, 13.5% as Hispanic, and 87.6% as white (Rural Health Information Hub, 2022).

→ Approximately half of the respondents held a high school diploma or the equivalent, and half had additional post-secondary education and/or degrees. All survey respondents lived in rural or frontier areas.

Table 1. Survey Respondent Demographics

Gender	No. of Responses
Female	16 (73%)
Male	5 (23%)
No response	1 (5%)

Racial or ethnic background	No. of Responses
American Indian or Alaska Native	5 (23%)
Hispanic/Latinx	4 (18%)
White	14 (64%)
Asian/Pacific Islander	1 (5%)

Languages typically spoken at home	No. of Responses
English	20 (91%)
Spanish	3 (14%)

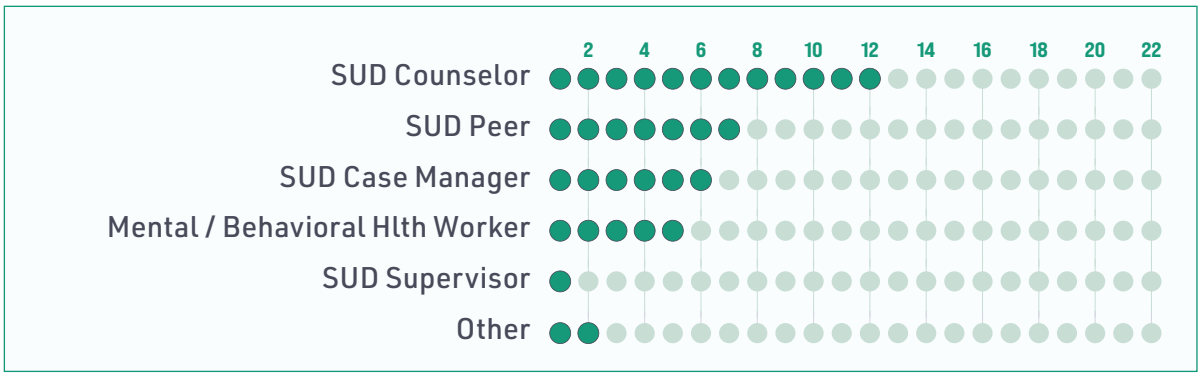
Urban, rural, or frontier zip code	No. of Responses
Rural	18 (82%)
Frontier	3 (14%)
Urban	0 (0%)

Highest level of education attained	No. of Responses
High school/GED	10 (45%)
Associates degree	3 (14%)
Bachelor's degree	2 (9%)
Master's degree	3 (14%)
Other	3 (14%)

Employment Characteristics

1. **All 22 survey respondents were employed, and 77% were in some type of SUD role.** (n=17, 77%)

   → Survey respondents could select more than one option to describe their role. Half were employed as SUD Counselors (n=12, 55%). Seven people (32%) indicated they were SUD Peers, 6 (27%) were SUD Case Managers, and 5 (23%) worked in mental health or behavioral health roles. One person (5%), reported being a SUD Peer Supervisor, one person was administrative staff (5%), and two respondents (9%) indicated "Other" (not currently in the field and in training).



2. **Most survey respondents were relatively new to their current employment role and likely to stay in their role for the next year.**

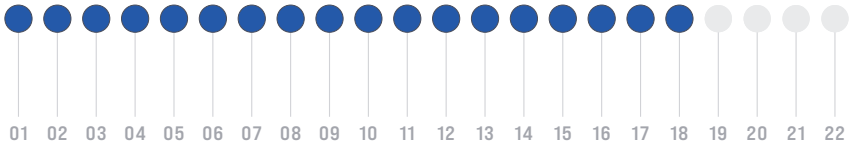
   → The average length of employment was 2.6 years, but ranged from 1-7 years. The most common length of employment reported was 1 year (n=5). Nine respondents (47%) worked for their current employer for less than 3 years, and 10 (53%) worked for their current employer for 3 or more years (3 people opted not to respond to this question). Most respondents (n=17, 77%) were very or somewhat likely to remain in their current employment for the next year. Five respondents (23%) were undecided, or somewhat or very unlikely to remain in their current employment for the next year.

Reasons for Attending the ETC Program

The top reason survey respondents attended the ETC program was:

To pursue their career goals and to increase their skills to better serve clients.

(n=18, 82%)



Other reasons include:

A desire to improve their credentials

(n=13, 59%)

To have better opportunities within their agency

(n=12, 55%)

For a new challenge

(n=12, 55%)

To attain a dual credential

(n=11, 50%)

For higher pay

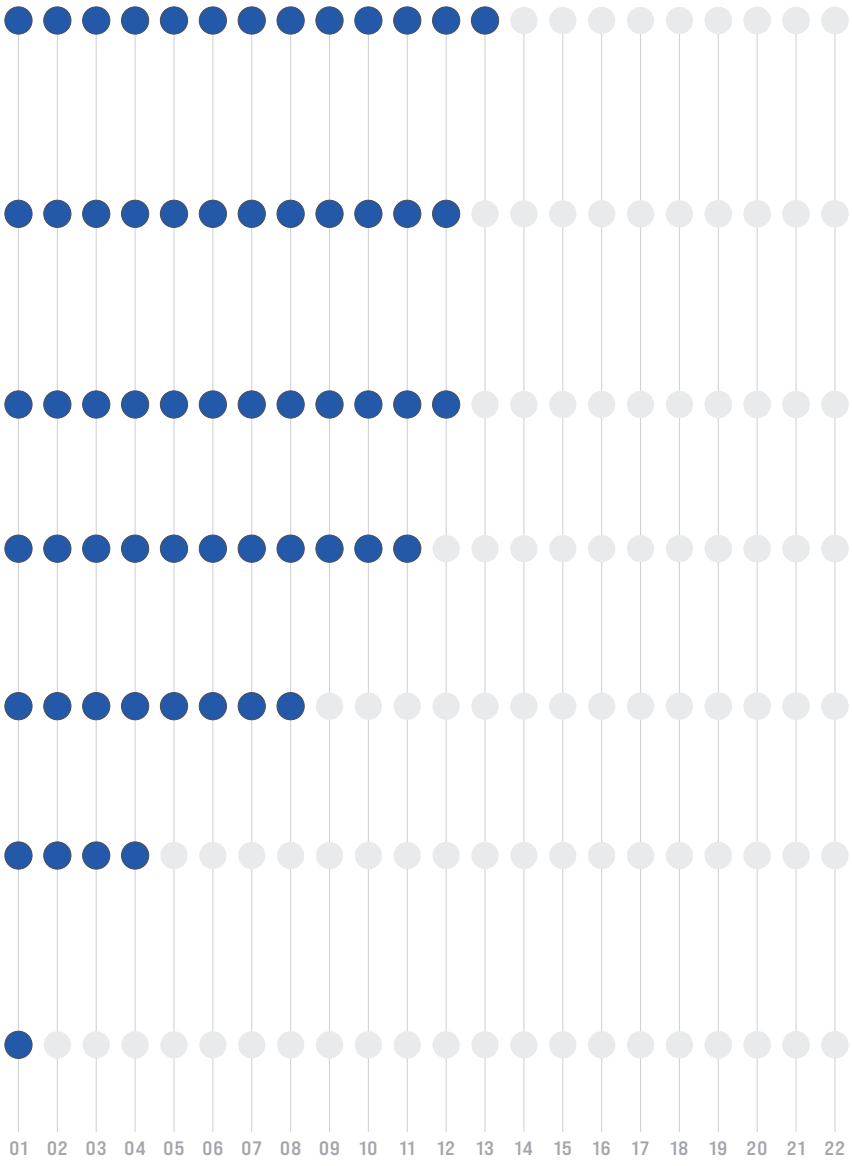
(n=8, 36%)

To support changing their career path

(n=4, 18%)

Required by their employer to participate in the program

(n=1, 5%)



Impact on Career Trajectories

1. **Most survey respondents planned to remain in their current employment for the next year.**

   → When asked about employment plans in the next year, two-thirds of respondents plan to maintain their current employment (n=15, 68%), and half plan to either increase their hours or advance in their positions (n=12, 55%).

2. **Most respondents said the ETC program improved their ability to do their work.**

   → Two-thirds (n=15, 68%) of respondents said that participating in the ETC program increased their knowledge and skills (e.g., motivational interviewing). Nearly a quarter of participants (n=5, 23%) also noted that the ETC program prepared them for certification, with some expressing appreciation for how this program alleviated the cost of the required education.

3. **Three of the 22 respondents attained their CADC credential within three months of completing ETC.**

   → One person (5%) completed the CADC certification, and two more (9%) passed the test and were waiting to receive their certification. Most respondents (n=16, 76%) had not taken the certification exam within three months of completing the program primarily because they needed to accrue supervised experience hours in addictions counseling (n=13, 62%). Of those who still need supervised hours, 61% (n=8) have at least half of their hours left to complete.

4. **ETC supported career pathways for people without post-secondary education and who are new to workforce.**

   → Nearly half of survey respondents did not have education beyond a GED or high school diploma, and/or worked for their current employer for less than three years. Developing career pathways through job training is especially important for communities that disproportionately face barriers to educational attainment (e.g., low income, rural/frontier, communities of color) (Baird et al., 2022).

5. **Some respondents have concerns about maintaining continuing education requirements for recertification.**

   → While ETC participants are on their way to completing the CADC credential, several respondents (n=6, 27%) were concerned about maintaining the continuing education requirements necessary for recertification.

Limitations

There are three key limitations to consider when interpreting these findings:

1. **Small sample size.** Only 22 people completed the survey, which limits the possibilities for disaggregating data by respondents' background characteristics. Future evaluation could continue to build on the findings of this survey, particularly considering the impacts of ETC for minoritized or other groups often marginalized by the health system (e.g., disabled, immigrant, LGBTQIA+).

2. **Short follow-up period.** This survey was distributed to participants three months after they completed the ETC program, which does not allow very much time for them to complete the CADC requirements (e.g., supervised experience hours). Continued evaluation of this program could strengthen understanding of how ETC and SOR2 funding contribute to the expansion of Oregon's SUD workforce with CADC credentials.

3. **Generalizability of findings.** PSU only surveyed those who completed ETC, thereby limiting findings to those who were able to fully access and be successful in the program. Future evaluations could include people who expressed interest in or began participating in ETC but did not complete the program to better understand barriers to access or participation.

Survey findings suggest that the ETC program, with targeted recruitment, expanded access to professional development opportunities for Oregon's rural/frontier SUD workforce.

Conclusion and Recommendations

The purpose of this evaluation was to assess the impact of SOR2 funding on Oregon's SUD workforce through the ETC program. Survey findings suggest that the ETC program, with targeted recruitment, expanded access to professional development opportunities for Oregon's rural/frontier SUD workforce. Overall, participants increased their knowledge and skills, advanced toward or attained a CADC certification, and indicated a commitment to remaining or expanding their role in the SUD field. ETC appears to offer a career pathway for those without post-secondary education, and survey respondents reflect greater diversity than Oregon's rural population in general, pointing to the potential for improving equitable opportunities in Oregon's SUD workforce.

Recommendations for ways to use future rounds of SOR funding to expand Oregon's SUD workforce include:

1. **Expand access to workforce development opportunities to other priority populations in Oregon.**

   → Through targeted recruitment, the ETC program was successful in expanding access to workforce development opportunities for people living in rural and frontier communities. Targeting other priority populations (e.g., Latinx and Native American communities) in future ETC cohorts would contribute to growing a diverse workforce that represents the population it serves, an important way to promote health equity (Santiago & Miranda, 2014).

2. **Offer workforce development opportunities, like ETC, in more languages.**

   → Most survey respondents spoke English and the first two cohorts of ETC were offered in English only. One way to remove barriers to accessing ETC is to offer the program in Spanish or other languages commonly spoken in Oregon (e.g., Russian, Vietnamese).

3. **Create opportunities for the SUD workforce to maintain their continuing education requirements.**

   → Although the ETC helped people move closer to attaining their CADC credential, there is some concern about accessing continuing education opportunities necessary for recertification. Funding ongoing educational opportunities, especially for those who disproportionately face barriers to such opportunities (due to race, language, geographical location, etc.), is an important way to maintain Oregon's SUD workforce.

4. **Develop strategies for addressing the challenges of attaining supervised experience hours.**

   → Most survey respondents were still working on accruing 1,000 supervised experience hours needed for CADC certification. Developing regional or statewide strategies to expand access to qualified supervisors is an important investment to increase the number of CADCs in Oregon.

For questions please contact:
Nicole Lauzus, nlauzus@pdx.edu

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Appendix I: Core Peer Training Follow Up Survey Report

Core Peer Training Follow Up Survey Report

AUTHORS

Nicole Lauzus

Carrie Furrer

Katie Shammel

Portland State University

For questions please contact:
Nicole Lauzus, nlauzus@pdx.edu

Introduction

The Oregon Health Authority (OHA) contracted with Portland State University (PSU) to conduct an impact evaluation of the second round of State Opioid Response funding (SOR2).[1] Part of the evaluation examined the impact of SOR2 funding on Oregon's workforce providing substance use disorder (SUD) treatment and recovery services. The Mental Health and Addiction Board of Oregon (MHACBO) received SOR2 funds to provide the OHA-approved Core Adult Addictions Peer Support training program at no cost to participants (referred to here as the "Core Peer training"). This 40-hour training program fulfills the education requirement for Certified Recovery Mentors (CRM) and Peer Support Specialists (PSS). Increasing the number of trained and certified peers can help remedy the ongoing shortage in the behavioral health workforce (Chapman et al., 2015), which is particularly dire when even before the COVID-19 pandemic almost 90% of people with substance use disorders did not receive treatment (Canady, 2021). Certification and placement on the Traditional Health Worker (THW) registry through OHA's Office of Equity and Inclusion[2] is required for peer-delivered services to be reimbursed by Medicaid; many organizations need their peer workforce to have these qualifications to remain financially viable (Medicaid and CHIP Payment and Access Commission [MACPAC], 2019).[3] The SOR2 funding goal was to expand Oregon's SUD workforce by increasing the number of certified peers.

1 The SOR2 funding period was September 30, 2020 through September 30, 2022.

2 https://www.oregon.gov/oha/OEI/Pages/THW-Become-Certified.aspx

3 Certified Recovery Mentors (CRMs) who have been placed on the MHACBO registry can bill state funding sources (e.g., Drug Addiction and Treatment Act [Measure 110] or other contracts) for services provided. All of the MHACBO-certified peers are also put on the OHA THW registry. Certified peers can also apply directly for placement on the THW registry, which has more stringent background check requirements and a separate administrative process.

OHA expresses a commitment to health equity in Oregon, achieved in part through the equitable distribution of resources.[4] With a lack of culturally- and linguistically-specific peer services in Oregon (Scavera & O'Neill-Tutor, 2020), it is important to recruit a diverse group of participants for the Core Peer training. MHACBO provided the Core Peer training in English and Spanish, marking an effort to make the training accessible for Spanish-speaking participants and to expand Oregon's SUD workforce to meet the needs of both English- and Spanish-speaking clients. There were six trainings with 169 total participants, one of which was conducted in Spanish (30 participants). PSU followed up with Core Peer training participants to learn about how the training influenced their career trajectories.

Evaluation Method

PSU created an online survey in collaboration with MHACBO and OHA partners. Like the Core Peer training, the survey was offered in both English and Spanish. The survey included questions about participants' motivations for pursuing the training program, progress towards a peer certification, and their career plans since completing the training. It also asked participants to share information about their background, including demographic data, education, and employment. PSU developed the brief (approximately 15-minute) survey using the Qualtrics survey platform, and it included multiple choice, rating scale, and open-ended questions.

PSU provided a link for the survey to a Core Peer trainer who then distributed the survey link and sent reminders via email. All survey respondents received a $30 Amazon gift card. The survey was distributed to training participants on April 1, 2022 and remained open until April 27, 2022. Of the 169 training participants, 112 people responded to the survey (66%); 8 of those survey respondents completed the survey in Spanish (7%). On average, participants responded to the survey five months after they completed the training (ranged from one to 13 months).[5] PSU analyzed the survey data using descriptive statistics and thematic analysis of qualitative responses.

4 https://www.oregon.gov/oha/oei/pages/health-equity-committee.aspx#:~:text=OHA%20and%20OHPB%20Health%20Equity%20Definition&text=The%20equitable%20distribution%20or%20redistribution,rectifying%20historical%20and%20contemporary%20injustices.

5 There were nine respondents who took the training prior to the SOR2 funding period, who are not represented here. Those nine respondents took the training between 24 and 72 months prior to completing the survey.

Survey Findings

The findings are based on responses from 112 individuals who completed the survey. It includes their demographic background and employment characteristics, reasons for taking the training, and impact on their career trajectories.

Background Characteristics

Most survey respondents identified as female and spoke English at home (see Table 1). One third of respondents identified as African American/Black, American Indian/Alaska Native, Hispanic/Latinx, or Native Hawaiian/Pacific Islander, and the remaining identified as white. This group of respondents represents greater diversity than Oregon's overall population (2% Black/African American, 2% American Indian/Alaska Native, and 75% as white; United States Census Bureau, 2020). Approximately half of respondents held a high school diploma or equivalent, and half had post-secondary education and/or advanced degrees. A quarter of respondents lived in rural or frontier areas, and the remaining lived in urban areas.

When asked about their current employment status, 84% (n=88) of respondents reported that they were employed. Of those employed, 91% (n=80) worked in full-time positions, and 9% (n=8) were employed part-time. Almost half of respondents (47%, n=41) indicated working in a peer role, and 88% (n=36) were in the SUD field. Other roles included:

- → Direct service behavioral health (e.g., case manager, counselor, navigator): 38% (n=33), and 24% (n=8) of these respondents worked in the SUD field
- → Administrative staff/program director: 8% (n=7)
- → Employed outside of the behavioral health/SUD field: 8% (n=7)

Table 1. Survey Respondent Demographics

Gender	No. of Responses
Female	71 (67%)
Male	30 (28%)
Non-Binary	n<5
Prefer not to say	n<5

Racial or ethnic background*	No. of Responses
African American/Black	9 (8%)
American Indian/Alaska Native	14 (13%)
Hispanic/Latinx	23 (22%)
Native Hawaiian/Pacific Islander	n<5
White	68 (61%)
Unknown	n<5

Languages typically spoken at home*	No. of Responses
English	99 (96%)
Spanish	16 (16%)
Brazilian Portuguese	n<5
Sign language	n<5

Urban, rural, or frontier zip code	No. of Responses
Rural/Frontier	27 (26%)
Urban	73 (71%)
Urban (out of state)	n<5

Highest level of education attained	No. of Responses
Some high school	7 (7%)
High school/GED	53 (51%)
Trade school	14 (13%)
Associate degree	17 (16%)
Bachelor's degree	9 (9%)
Graduate degree	n<5
Other	n<5

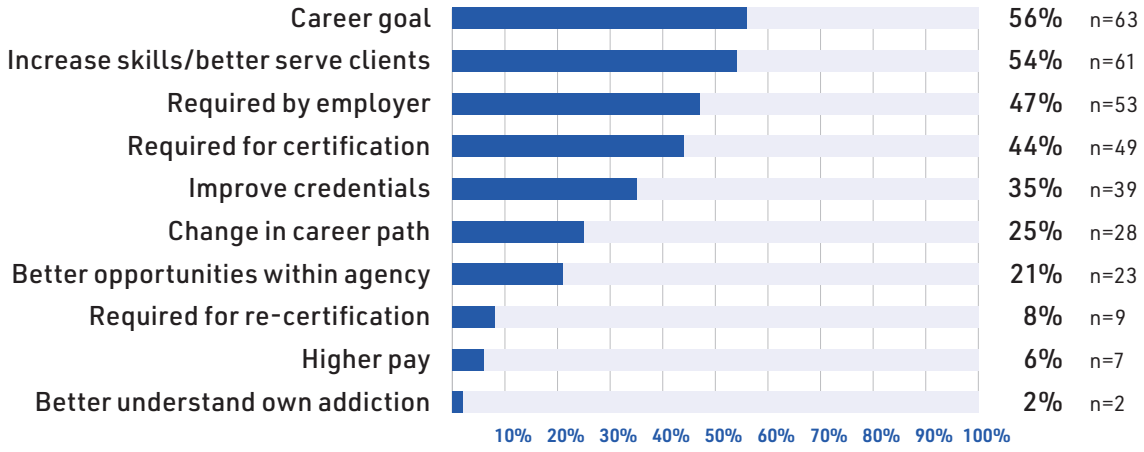
* Respondents could choose more than one response.
Note: n<5 is masked due to small sample sizes.

Most respondents attended the Core Peer training to further their careers.

Over half of the respondents indicated they attended the training to pursue a career goal (56%, n=63) or increase their skills and better serve clients (54%, n=61). Figure 1 shows the reasons that respondents took the Core Peer training (respondents could select more than one reason). It is noteworthy that a quarter of respondents attended the training to change their career path (25%, n=28). Interestingly, higher pay was not a common reason that respondents participated in the training (6%, n=7).

"This training was amazing and helped me take the next steps in changing career paths. I'm super grateful that this was available and it was very helpful to have to virtually."

Figure 1. Reasons for taking Core Peer training



The Core Peer training positively impacted participants' career trajectories in terms of certification, encouraging new people to enter the peer workforce, and retention.

Most survey respondents attained peer certifications after the Core Peer training.

Three-fourths (n=80) of respondents earned a new peer certification (CRM, PSS, or PWS) after the training. For 72 of these respondents (90%), it was their first ever peer certification. Moreover, a large proportion of respondents who were unemployed attained a new peer certification (16 of 19, or 84%). Taken together, these findings suggest that the Core Peer training contributed to expanding the peer workforce by supporting the certification of those who were already employed, and by helping those who were unemployed have more opportunities to be hired. Some respondents noted that they would not have been able to attain their certification without this free training.

While 84% (n=86) of respondents reported no challenges to attaining certification, others experienced barriers in the certification process, such as cost (9%, n=9), having two years of recovery (n<5), or passing a criminal background check (n<5). It is important to note that a larger share of respondents identifying as African American/Black, Hispanic/Latinx, or with multiple racial backgrounds experienced one or more of these barriers. We also found that a smaller share of African American/Black and Hispanic/Latinx respondents attained peer certification since the Core Peer training compared to respondents who identified with other racial groups. These findings suggest that racial inequities may be perpetuated through systemic barriers in the certification process. In particular, systemic racism creates conditions in which Black people face higher rates of criminal convictions (The Sentencing Project, 2018), and Black and Hispanic families experience higher rates of poverty (Wilson, 2020).

"I would have not been able to afford the certifications and training if not for it being offered through MHACBO."

Some respondents had concerns about maintaining continuing education requirements for recertification.

While most respondents attained and/or were in the process of attaining certification, many (23%, n=24) were concerned about the cost of continuing education unit (CEU) requirements. One respondent explained, **"If there were more CEU opportunities that were free, it would be very beneficial. Not just for recertification purposes, but for professional development opportunities and additional training with staff we are working with."** Additionally, 15% of respondents (n=16) were concerned about the availability of continuing education opportunities (see also Scavera & O'Neill-Tutor, 2020, which identified similar concerns among Oregon's peer workforce).

Like the challenges for earning certification, concerns about maintaining continuing education requirements also highlight how systemic racism perpetuates inequitable barriers to recertification. A larger share of respondents who identified with multiple racial backgrounds had concerns about the cost and availability of continuing education opportunities. We also found that a higher proportion of respondents identifying as Hispanic/Latinx were concerned about a lack of continuing education opportunities that were related to their interests. Most notably, a larger share of respondents who identified as African American/Black, American Indian/Alaska Native, and Hispanic/Latinx expressed concern about a lack of culturally relevant continuing education opportunities. One participant recommended "un poco mas e informacion al publico de estas oportunidades. Informacion de lugares para obtener CEU's en espanol [a little more and information to the public about these opportunities. Information on places to obtain CEU's in Spanish]."

"un poco mas e informacion al publico de estas oportunidades. Informacion de lugares para obtener CEU's en espanol [a little more and information to the public about these opportunities. Information on places to obtain CEUs in Spanish]."

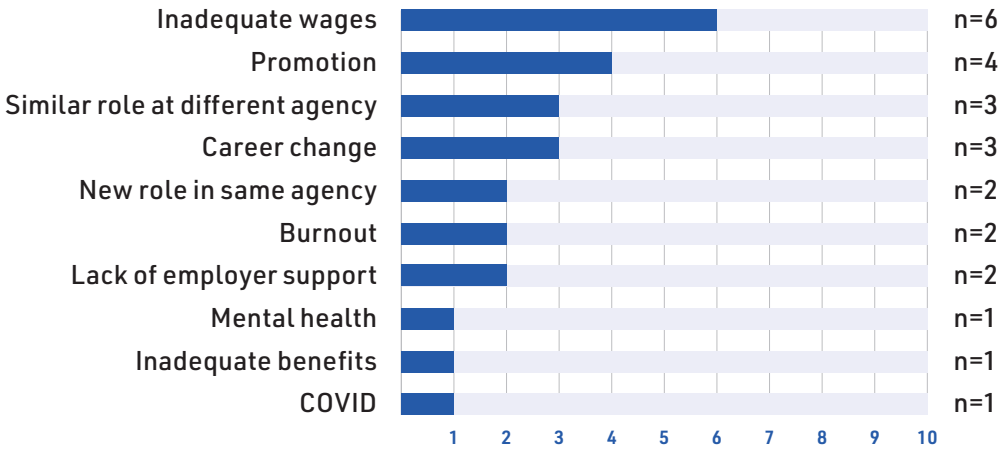
Most respondents planned to remain in their current roles over the next year.

Eighty-three percent (n=73) indicated they will remain in their roles for the coming year. Respondents also reported plans to advance in behavioral health (42%, n=37) and/or go back to school (18%, n=16). When asked about future career plans, nearly all respondents were "very likely" or "somewhat likely" to remain in their current position over the next year (78%, n=69 and 15%, n=13, respectively).

Inadequate wages were the primary reason respondents were undecided or unlikely to remain in their current roles.

When asked why they were thinking about leaving their current role next year, most of the respondents (85%, or 6 of the 7 who were undecided or unlikely to remain in their current role) pointed to inadequate wages. Improving wages is a strategy for expanding and maintaining Oregon's peer workforce (Scavera & O'Neill-Tutor, 2020). As previously noted, higher pay was generally not the reason that respondents attended the training, suggesting a potential disconnect between attaining credentials and compensation. Figure 2 shows the reasons that respondents were undecided or unlikely to remain in their current roles (respondents could select more than one). Aside from inadequate wages, the next most common reasons reflected a desire to remain in the SUD workforce (all n<5): earning a promotion, moving to a similar role at a different agency, and moving to a new role at the same agency. The remaining reasons were making a career change, lack of employer support, burnout, inadequate benefits, mental health issues, and/or COVID-19.

Figure 2. Reasons for being undecided or unlikely to remain in employment



Recommendations for ways to use future rounds of SOR funding to expand Oregon's SUD workforce include:

1. **Increase access to peer certification and recertification.**

   → Respondents noted concerns about attaining certification and recertification, a finding that aligns with a recent MHACBO report suggesting that 17.4% of CRMs did not recertify or request a COVID extension to recertify in 2020 (MHACBO, 2021). Future SOR funding could subsidize the cost of certification, recertification, and required training. Additionally, SOR funding could contribute to the needed diversification of Oregon's SUD peer workforce by funding culturally- and linguistically-specific training and continuing education opportunities (see also Scavera & O'Neill-Tutor, 2020 for a similar recommendation).

   Not only should these opportunities be offered in multiple languages and the content reflect diverse cultures, but the outreach should be linguistically and culturally relevant for diverse groups of participants. To this end, culturally specific organizations and community members should be included in developing training content and designing outreach efforts. Some examples are transcreating outreach and training materials (i.e., go beyond literal translation to ensure the materials makes sense from a cultural perspective); expanding outreach efforts to include specific communities' trusted messengers and channels of communication; and reviewing, revising, and/or developing new training content to increase cultural relevance (e.g., communities of color, rural/frontier communities, LGBTQIA+, immigrants).

2. Advocate for re-evaluating peer certification requirements.

→ OHA should consider advocating for Medicaid to use MHACBO's certified peer registry along with advocating for changes to the requirements needed for placement on the TWH registry, particularly related to more flexibility for criminal background checks. Scavera and O'Neill-Tutor (2020) echo this recommendation for Oregon's peer workforce, also highlighting the disproportionate impact on people of color who are more likely to be arrested and convicted of crimes. Moreover, peers' lived experience is a critical part of their success in working with people with SUD; in this way, having experience in the criminal justice system is an asset for peers (Reingle Gonzalez et al., 2019).

3. Support alternate funding sources for non-certified peers.

→ Peers on the MHACBO registry can bill for services from state funding sources, but they must be on OHA's THW registry to secure Medicaid reimbursement, which many organizations need to sustainably fund these positions. Although certification has created a pathway to sustainably fund peers, it has also had perhaps unintended impacts on service delivery. Certification promotes professionalization of the peer role, which can lead to less flexibility and individualized work with clients, making it more formal and less relational (Adams, 2020). As discussed above, certification requirements also limit who can become a peer, which restricts how much peer workforce expansion is possible (Adams, 2020). OHA might consider promoting alternatives that fund peer positions through state and local funding or federal grants, for example, by providing technical assistance to and supporting infrastructure development for organizations to access funding outside of Medicaid reimbursement (Chapman et al., 2015).

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For questions please contact:
Nicole Lauzus, nlauzus@pdx.edu

Appendix J: Informe de la encuesta de seguimiento de la capacitación básica entre pares

Informe de la encuesta de seguimiento de la capacitación básica entre pares

AUTORAS

Nicole Lauzus

Carrie Furrer

Katie Shammel

Portland State University

Si tiene preguntas, póngase en contacto con:
Nicole Lauzus, nlauzus@pdx.edu

Introducción

La Autoridad de Salud de Oregon (OHA, por sus siglas en inglés) contrató a la Universidad Estatal de Portland (PSU, por sus siglas en inglés) para que lleve a cabo una evaluación de impacto de los fondos destinados a la segunda ronda de la Respuesta estatal a los opiáceos (SOR2, por sus siglas en inglés).[1] Parte de la evaluación examinó el impacto de los fondos destinados a la SOR2 en el personal de Oregon que presta servicios para el tratamiento y la recuperación del trastorno por consumo de sustancias (SUD, por sus siglas en inglés). La Junta de Certificación de Salud Mental y Adicciones de Oregon (MHACBO, por sus siglas en inglés) recibió los fondos destinados a la SOR2 para ofrecer el programa de capacitación Apoyo básico entre pares para la recuperación de adicciones en adultos, aprobado por la OHA,[2] sin costo alguno para los participantes (denominado aquí "capacitación básica entre pares"). Este programa de capacitación de 40 horas cumple con el requisito de educación para los mentores de recuperación certificados (CRM, por sus siglas en inglés) y los especialistas en apoyo de pares (PSS, por sus siglas en inglés). Aumentar la cantidad de pares capacitados y certificados puede ayudar a remediar la actual escasez de personal de salud del comportamiento (Chapman et al., 2015), que es especialmente grave cuando, incluso antes de la pandemia de COVID-19, casi el 90 % de las personas con trastornos por consumo de sustancias no recibían tratamiento (Canady, 2021). Se requiere la certificación y la incorporación al registro de trabajadores de salud tradicional (THW, por sus siglas en inglés) mediante la Oficina de Equidad e Inclusión de la OHA para que Medicaid reembolse los servicios prestados por pares; muchas organizaciones necesitan que su personal de pares cuente con esas calificaciones para seguir siendo financieramente viables (Comisión de Pago y Acceso a Medicaid y Programa de Seguro Médico para Niños [MACPAC, por sus siglas en inglés], 2019).[3] El objetivo de los fondos destinados a la SOR2 era ampliar el personal para SUD de Oregon al aumentar la cantidad de pares certificados.

1 El período de los fondos destinados a la SOR2 fue del 30 de septiembre de 2020 al 30 de septiembre de 2022.

2 https://www.oregon.gov/oha/OEI/Pages/THW-Become-Certified.aspx

3 Los mentores de recuperación certificados (CRM) que han sido incorporados al registro de la MHACBO pueden facturarle a fuentes de fondos estatales (p. ej., la Ley de Tratamiento de Adicciones a Drogas [Propuesta 110] u otros contratos) por los servicios prestados. Todos los pares certificados por la MHACBO también son incluidos en el registro de THW de la OHA. Los pares certificados también pueden solicitar directamente su incorporación al registro de THW, que tiene unos requisitos de verificación de antecedentes más estrictos y un proceso administrativo independiente.

La OHA expresa su compromiso con la equidad en la salud en Oregon, que se logra en parte mediante la distribución equitativa de los recursos.[4] Con la falta de servicios de pares cultural y lingüísticamente específicos en Oregon (Scavera y O'Neill-Tutor, 2020), es importante reclutar un grupo diverso de participantes para la capacitación básica entre pares. La MHACBO proporcionó la capacitación básica entre pares en inglés y en español, lo que señala un esfuerzo por facilitar el acceso a la capacitación a participantes de habla hispana y por ampliar el personal para SUD de Oregon a fin de satisfacer las necesidades de clientes que hablan inglés y español. Hubo seis capacitaciones con 169 participantes en total, una de las cuales se impartió en español (30 participantes). La PSU hizo un seguimiento de los participantes de la capacitación básica entre pares para saber cómo influyó la capacitación en sus trayectorias profesionales.

Método de evaluación

La PSU creó una encuesta en línea junto con colaboradores de la MHACBO y la OHA. Al igual que la capacitación básica entre pares, la encuesta se ofreció en inglés y en español. La encuesta incluyó preguntas sobre las motivaciones de los participantes para realizar el programa de capacitación, el progreso para obtener una certificación de pares y sus planes profesionales desde que completaron la capacitación. También se pidió a los participantes que compartieran información sobre sus antecedentes, como datos demográficos, educación y empleo. La PSU elaboró la breve encuesta (de aproximadamente 15 minutos), mediante la plataforma de encuestas Qualtrics, e incluyó preguntas de opciones múltiples, escala de calificación y preguntas abiertas.

La PSU proporcionó un enlace a la encuesta a un capacitador de la capacitación básica entre pares, quien luego distribuyó el enlace a la encuesta y envió recordatorios por correo electrónico. Todos los encuestados recibieron una tarjeta de regalo de Amazon de $30. La encuesta se distribuyó a los participantes de la capacitación el 1 de abril de 2022 y permaneció abierta hasta el 27 de abril de 2022. De los 169 participantes de la capacitación, 112 personas respondieron la encuesta (66 %); 8 de esos encuestados completaron la encuesta en español (7 %). En promedio, los participantes respondieron la encuesta cinco meses después de haber completado la capacitación (entre uno y 13 meses).[5] La PSU analizó los datos de la encuesta con estadísticas descriptivas y un análisis temático de las respuestas cualitativas.

4 https://www.oregon.gov/oha/oei/pages/health-equity-committee.aspx#:~:text=OHA%20and%20OHPB%20Health%20Equity%20Definition&text=The%20equitable%20distribution%20or%20redistribution,rectifying%20historical%20and%20contemporary%20injustices.

5 Hubo nueve encuestados que realizaron la capacitación antes del período de los fondos destinados a la SOR2, que no están representados aquí. Esos nueve encuestados realizaron la capacitación entre 24 y 72 meses antes de haber completado la encuesta.

Resultados de la encuesta

Los resultados se basan en las respuestas de 112 personas que completaron la encuesta. Dicha encuesta incluye sus antecedentes demográficos y las características de empleo, los motivos por los que han realizado la capacitación y el impacto en sus trayectorias profesionales.

Características generales de los participantes de la encuesta

La mayoría de los encuestados se identificaron como mujeres y hablaban inglés en su hogar (consulte la Tabla 1). Un tercio de los encuestados se identificaron como afroestadounidenses[6] y/o negras/os/x, indígenas estadounidenses/nativas/os/x de Alaska, hispanas/os/x y/o latinas/os/x o nativas/os/x de Hawái/de las Islas del Pacífico, y el resto se identificaron como blancas/os/x. Este grupo de encuestados representa una mayor diversidad que la población general de Oregon (2 % de negras/os/x/ afroaestadounidenses, 2 % de indígenas estadounidenses/nativas/os/x de Alaska y 75 % de blancas/os/x; Oficina del Censo de Estados Unidos, 2020). Aproximadamente la mitad de los encuestados tenían un diploma de preparatoria o equivalente, y la mitad tenían educación posterior a la preparatoria y/o estudios superiores. Una cuarta parte de los encuestados vivían en áreas rurales o fronterizas, y el resto en áreas urbanas.

6 En este informe utilizamos categorías de identidad racial/étnica "a/o/x" en un esfuerzo por utilizar un lenguaje neutral en cuanto al género.

Cuando se les preguntó por su condición laboral actual, el 84 % (n=88) de los encuestados informaron tener empleo. De los encuestados con empleo, el 91 % (n=80) trabajaban en puestos a tiempo completo y el 9 % (n=8) tenían empleos a tiempo parcial. Casi la mitad de los encuestados (47 %, n=41) indicaron que trabajaban en una función de pares y el 88 % (n=36) lo hacían en el ámbito de SUD. Otras funciones fueron las siguientes:

- → Salud del comportamiento de servicio directo (p. ej., administrador de casos, consejero, guía): el 38 % (n=33) y el 24 % (n=8) de esos encuestados trabajaban en el ámbito de SUD.
- → Personal administrativo/director del programa: 8 % (n=7).
- → Empleo fuera del ámbito de salud del comportamiento/SUD: 8 % (n=7).

Tabla 1. Datos demográficos de los encuestados

Género	# (%)
Mujer	71 (67%)
Hombre	30 (28%)
No binario	n<5
Prefiero no decir	n<5

Origen racial y étnico*	# (%)
afroestadounidense y/o negra/o/x	9 (8%)
indígena estadounidense y/o nativa/o/x de Alaska	14 (13%)
hispana/o/x y/o latina/o/x	23 (22%)
nativa/o/x de Hawái/de las Islas del Pacífico	n<5
blanca/o/x	68 (61%)
Se desconoce	n<5

Idiomas que se hablan en el hogar	# (%)
ingles	99 (96%)
español	16 (16%)
portugués de Brasil	n<5
lenguaje de señas;	n<5

Código postal de área fronteriza, rural o urbana	# (%)
Área rural/fronteriza	27 (26%)
Área urbana	73 (71%)
Área urbana (fuera del estado)	n<5

Nivel más alto de educación alcanzado	# (%)
Algo de escuela secundaria (preparatoria)	7 (7%)
Preparatoria/Desarrollo Educativo General (GED, por sus siglas en inglés)	53 (51%)
Escuela de oficios	14 (13%)
Grado técnico superior	17 (16%)
Licenciatura	9 (9%)
Título de posgrado	n<5
Otro	n<5

*En este informe utilizamos categorías de identidad racial/étnica "a/o/x" en un esfuerzo por utilizar un lenguaje neutral en cuanto al género. Los encuestados podrían elegir más de una respuesta.
Nota: n <5 es con enmascaramiento debido al pequeño tamaño de la muestra.

La mayoría de los encuestados asistieron a la capacitación básica entre pares para avanzar en sus carreras profesionales.

Más de la mitad de los encuestados indicaron que asistieron a la capacitación para lograr su meta profesional (56 %, n=63) o para aumentar sus habilidades y prestar un mejor servicio a los clientes (54 %, n=61). En la Figura 1, se señalan los motivos por los que los encuestados realizaron la capacitación básica entre pares (los encuestados podían seleccionar más de un motivo). Cabe destacar que una cuarta parte de los encuestados asistieron a la capacitación para cambiar la trayectoria de su carrera profesional (25 %, n=28). Resulta interesante que una mayor remuneración no fuera un motivo frecuente para que los encuestados participaran en la capacitación (6 %, n=7).

"Esta capacitación fue increíble y me ayudó a dar los siguientes pasos para cambiar la trayectoria de mi carrera profesional. Estoy súper agradecido de que esto estuviera disponible y fue muy útil poder acceder de manera virtual."

Figura 1. Razones para tomar la capacitación Core Peer

La capacitación básica entre pares tuvo un impacto positivo en las trayectorias profesionales de los participantes en términos de certificación, motivación para que nuevas personas formen parte del personal de pares y retención.

La mayoría de los encuestados obtuvieron la certificación de pares después de la capacitación básica entre pares.

Las tres cuartas partes (n=80) de los encuestados obtuvieron una nueva certificación de pares (CRM, PSS o especialista en bienestar de pares [PWS, por sus siglas en inglés]) después de la capacitación. Para 72 de esos encuestados (90 %), se trató de su primera certificación de pares. Además, una gran proporción de los encuestados que estaban desempleados obtuvieron una nueva certificación de pares (16 de 19 o el 84 %). Considerados conjuntamente, estos resultados sugieren que la capacitación básica entre pares contribuyó a ampliar el personal de pares al apoyar la certificación de quienes ya tenían empleo y al ayudar a quienes estaban desempleados a tener más oportunidades de ser contratados. Algunos encuestados indicaron que no hubieran podido obtener su certificación sin esta capacitación gratuita.

"No habría podido pagar las certificaciones ni la capacitación si no se hubiera ofrecido mediante la MHACBO."

Aunque el 84 % (n=86) de los encuestados no informaron ninguna dificultad para obtener la certificación, otros enfrentaron obstáculos en el proceso de certificación, como el costo (9 %, n=9), tener dos años de recuperación (n <5) o pasar una verificación de antecedentes penales (n <5). Es importante señalar que una mayor proporción de encuestados que se identificaron como afroestadounidenses y/o negras/os/x, hispanas/os/x y/o latinas/os/x o multirraciales enfrentaron uno o más de esos obstáculos. También descubrimos que una menor proporción de encuestados afroestadounidenses y/o negras/os/x e hispanas/os/x y/o latinas/os/x obtuvieron la certificación

de pares desde la capacitación básica entre pares en comparación con los encuestados que se identificaron con otros grupos raciales[7]. Estos resultados sugieren que las faltas de equidad racial pueden perpetuarse con obstáculos sistémicos en el proceso de certificación. En especial, el racismo sistémico genera condiciones en las que las personas de raza negra se enfrentan a tasas más altas de condenas penales (The Sentencing Project, 2018), y las familias de raza negra o de origen hispana/o/x y/o latina/o/x tienen tasas más altas de pobreza (Wilson, 2020).

Algunos encuestados tuvieron inquietudes con respecto a cumplir con los requisitos de educación continua para la recertificación.

Aunque la mayoría de los encuestados obtuvieron y/o estaban en proceso de obtener la certificación, muchos (23 %, n=24) tenían inquietudes con respecto al costo de los requisitos de las unidades de educación continua (CEU, por sus siglas en inglés). Un encuestado explicó: **"Si hubiera más oportunidades de CEU que fueran gratuitas, sería muy beneficioso. No solo para los fines de la recertificación, sino también para las oportunidades de desarrollo profesional y la capacitación adicional con el personal con el que trabajamos".** Además, el 15 % de los encuestados (n=16) tenían inquietudes con respecto a la disponibilidad de las oportunidades de educación continua (consulte también Scavera y O'Neill-Tutor, 2020, que identificaron inquietudes similares entre el personal de pares de Oregon).

Al igual que los desafíos para obtener la certificación, las inquietudes con respecto a cumplir con los requisitos de educación continua también ponen de manifiesto cómo el racismo sistémico perpetúa los obstáculos no equitativos para la recertificación. Una mayor proporción de encuestados que se identificaron con múltiples orígenes raciales tuvieron inquietudes con respecto al costo y a la disponibilidad de las oportunidades de educación continua. También descubrimos que una mayor proporción de encuestados que se identificaron como hispanas/os/x y/o latinas/os/x tenían inquietudes con respecto a la falta de oportunidades de educación continua relacionadas con sus intereses. Particularmente, una mayor proporción de encuestados que se identificaron como afroestadounidenses/negras/os/x, indígenas estadounidenses/nativas/os/x de Alaska e hispanas/os/x y/o latinas/os/x expresaron su inquietud con respecto a la falta de oportunidades de educación continua culturalmente relevantes. Un participante recomendó "un poco más de información al público de estas oportunidades. Información de lugares para obtener CEU en español".

"un poco mas e informacion al publico de estas oportunidades. Informacion de lugares para obtener CEU's en espanol."

7 Las cifras no se presentan debido a la confidencialidad y al pequeño tamaño de las muestras.

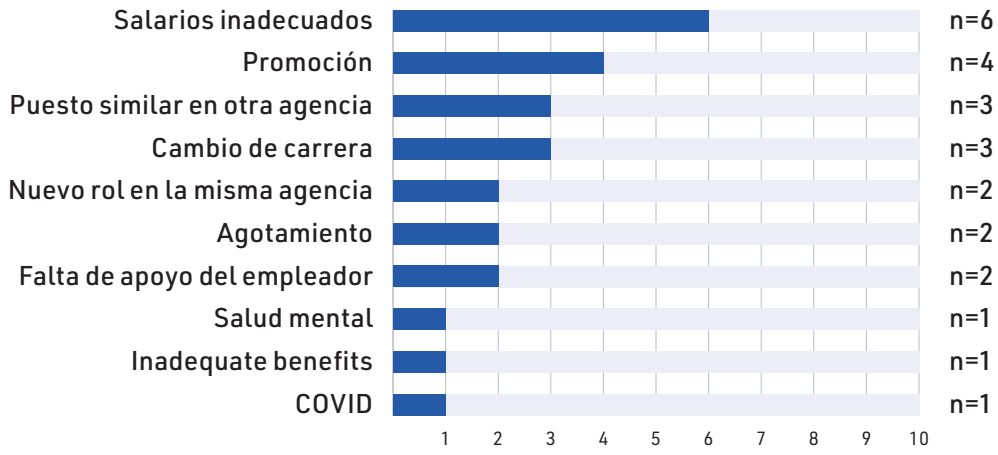
La mayoría de los encuestados tenían previsto permanecer en sus funciones actuales durante el próximo año.

El 83 % (n=73) indicaron que permanecerán en sus funciones durante el próximo año. Los encuestados también informaron sus planes de avanzar en el área de salud del comportamiento (42 %, n=37) y/o de retomar los estudios (18 %, n=16). Cuando se les preguntó por sus planes profesionales futuros, casi todos los encuestados indicaron que era "muy probable" o "algo probable" que permanecieran en su puesto actual durante el próximo año (78 %, n=69, y 15 %, n=13, respectivamente).

Los salarios inadecuados fueron el principal motivo por el que los encuestados indicaron estar indecisos o que era improbable que permanecieran en sus funciones actuales.

Cuando se les preguntó por qué pensaban dejar su función actual el próximo año, la mayoría de los encuestados (el 85 % o 6 de los 7 que indicaron estar indecisos o que era improbable que permanecieran en su función actual) señalaron los salarios inadecuados. La mejora de los salarios es una estrategia para ampliar y mantener el personal de pares de Oregon (Scavera y O'Neill-Tutor, 2020). Como se señaló anteriormente, una mayor remuneración no fue en general el motivo por el que los encuestados asistieron a la capacitación, lo que sugiere una posible desconexión entre la obtención de credenciales y la compensación. En la Figura 2, se señalan los motivos por los que los encuestados indicaron estar indecisos o que era improbable que permanecieran en sus funciones actuales (los encuestados podían seleccionar más de una opción). Aparte de los salarios inadecuados, los siguientes motivos más frecuentes reflejaron el deseo de seguir siendo parte del personal para SUD (todos n< 5): obtener un ascenso, cambiar a una función similar en una agencia diferente y cambiar a una nueva función en la misma agencia. Los motivos restantes fueron el cambio de carrera, la falta de apoyo del empleador, el agotamiento, los beneficios inadecuados, los problemas de salud mental y/o el COVID-19.

Figura 2. Razones para estar indeciso o con pocas probabilidades de permanecer en el empleo



Recomendaciones para la OHA y los futuros fondos destinados a la SOR:

1. **Aumentar el acceso a la certificación y la recertificación de pares.**

   → Los encuestados señalaron su inquietud con respecto a la obtención de la certificación y la recertificación, un resultado que se alinea con un reciente informe de la MHACBO que sugiere que el 17.4 % de los CRM no recertificaron ni solicitaron una prórroga debido al COVID-19 para recertificar en 2020 (MHACBO, 2021). Los futuros fondos destinados a la SOR podrían subsidiar el costo de la certificación, la recertificación y la capacitación obligatoria. Además, los fondos destinados a la SOR podrían contribuir a la necesaria diversificación del personal de pares para SUD de Oregon mediante la financiación de oportunidades de capacitación y educación continua cultural y lingüísticamente específicas (consulte también Scavera y O'Neill-Tutor, 2020 para conocer una recomendación similar). Estas oportunidades no solo deben ofrecerse en varios idiomas y el contenido debe reflejar diversas culturas, sino que también las actividades de divulgación deben ser lingüística y culturalmente relevantes para diversos grupos de participantes. Para ello, las organizaciones y los miembros de la comunidad culturalmente específicos deben ser incluidos en el desarrollo del contenido de la capacitación y en el diseño de las iniciativas de las actividades de divulgación. Algunos ejemplos son la transcreación de los materiales de las actividades de divulgación y de las capacitaciones (es decir, ir más allá de la traducción literal para garantizar que los materiales tengan sentido desde una perspectiva cultural); la ampliación de las iniciativas de las actividades de divulgación para incluir a los mensajeros y los canales de comunicación de confianza de comunidades específicas; y la revisión, el análisis y/o el desarrollo de nuevos contenidos de capacitación para aumentar la relevancia cultural (p. ej., comunidades de color, comunidades de áreas rurales/fronterizas, miembros de la comunidad LGBTQIA+, inmigrantes).

2. Abogar por la reevaluación de los requisitos de certificación de pares.

→ La OHA debe considerar la posibilidad de abogar para que Medicaid use el registro de pares certificados de la MHACBO y de abogar por los cambios en los requisitos necesarios para la incorporación al registro de TWH, en especial en relación con una mayor flexibilidad para la verificación de antecedentes penales. Scavera y O'Neill-Tutor (2020) se hacen eco de esta recomendación para el personal de pares de Oregon y destacan también el impacto desproporcionado en las personas de color que tienen más probabilidades de ser arrestadas y condenadas por delitos. Además, la experiencia vivida de los pares es una parte fundamental de su éxito en el trabajo con personas con SUD; de este modo, tener experiencia en el sistema de justicia penal es una ventaja para los pares (Reingle Gonzalez et al., 2019).

3. Apoyar las fuentes de fondos alternativas para los pares no certificados.

→ Los pares que figuran en el registro de la MHACBO pueden facturare sus servicios a fuentes de fondos estatales, pero deben estar en el registro de THW de la OHA para obtener el reembolso de Medicaid, que muchas organizaciones necesitan para financiar de manera sostenible esos puestos. Aunque la certificación ha creado una vía para financiar de manera sostenible a los pares, también ha tenido efectos quizá no deseados en la prestación de servicios. La certificación promueve la profesionalización de la función de pares, que puede derivar en menos flexibilidad y trabajo individualizado con los clientes, lo que haría que sea más formal y menos relacional (Adams, 2020). Como ya se mencionó anteriormente, los requisitos de certificación también limitan quién puede convertirse en par, lo que restringe el grado de ampliación del personal de pares (Adams, 2020). La OHA podría considerar la promoción de alternativas que financien los puestos de pares mediante fondos estatales y locales o subvenciones federales; por ejemplo, al proporcionar asistencia técnica y al apoyar el desarrollo de infraestructuras para que las organizaciones accedan a los fondos más allá del reembolso de Medicaid (Chapman et al., 2015).

Si tiene preguntas, póngase en contacto con:
Nicole Lauzus, nlauzus@pdx.edu

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Racial disparities in income and poverty remain largely unchanged amid strong income growth in 2019.

Appendix K: Education Toward CADC (ETC) Follow Up Survey Infographic

Education Toward CADC (ETC) Follow-Up Survey

The Oregon Health Authority (OHA) used the State Opioid Response Grant to fund the Education Toward CADC (ETC) training program for two cohorts of participants between June and December 2021. ETC provides the 150 hours of education needed for a Certified Alcohol & Drug Counselor I (CADC I) credential. OHA contracted with Portland State University to follow up with the 32 participants who completed ETC to evaluate the impact it had on their careers. Of those who completed, 22 participants (71%) responded to the follow-up survey distributed 3 months after ETC completion.

Oregon Health Authority

Portland State University

Janis Crawford LLC
Education Toward CADC ~ ETC PROGRAM

ETC supported Oregon's SUD workforce in preparing for or attaining certification, improving skills and pursing career goals, and maintaining employment.

↗ Respondents made progress toward CADC certification

Of the 22 survey respondents:

3 people received their CADC credential or passed the certification test within just three months of completing ETC

Of the 19 people still working on requirements:

5 people have only the certification exam left to take

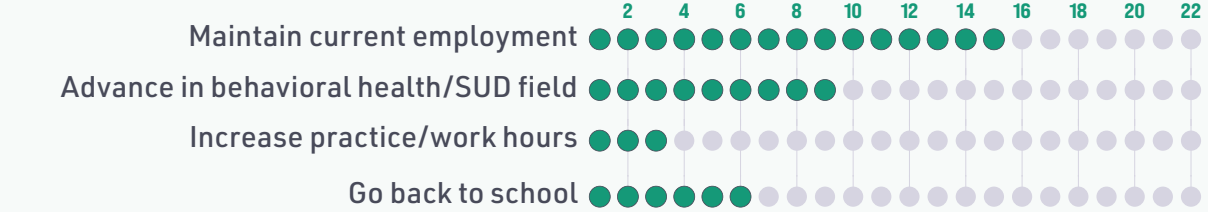
13 people need to complete their supervised experience hours and take the certification exam

↗ Respondents were interested in improving skills and pursuing career goals

The top 5 reasons for participating in ETC were:

> **"The ETC program provided amazing training on substance use, addiction, trauma informed care and groups that improved me as a clinician and provided me with the education needed to become dual certified."**

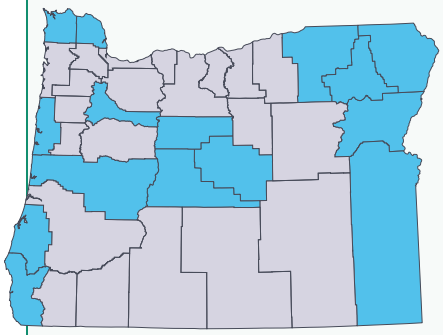
↗ Most survey respondents planned to continue or advance their employment in the next year



> **"It allowed me to gain my schooling that might have had barriers such as money and time from work to achieve them. I have knowledge of the job I have been training for now."**

ETC expanded access to CADC training for priority populations in Oregon.

↗ Worked in 15 rural/frontier counties



The training was offered to Oregon's rural/ frontier workforce, identified as a priority population due to limited professional development opportunities and workforce shortages.

Targeted recruitment expanded access to training in counties highly affected by the opioid crisis

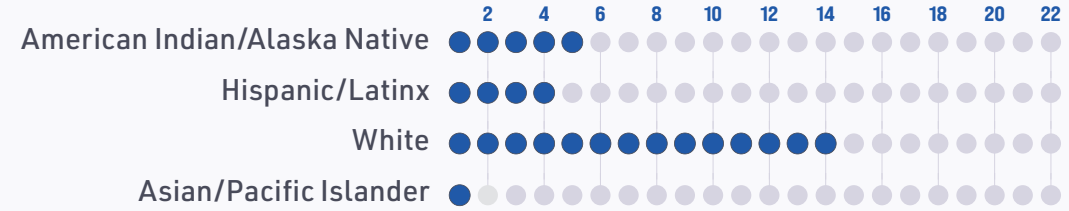
↗ Mostly spoke English*

3 people typically spoke **Spanish** at home

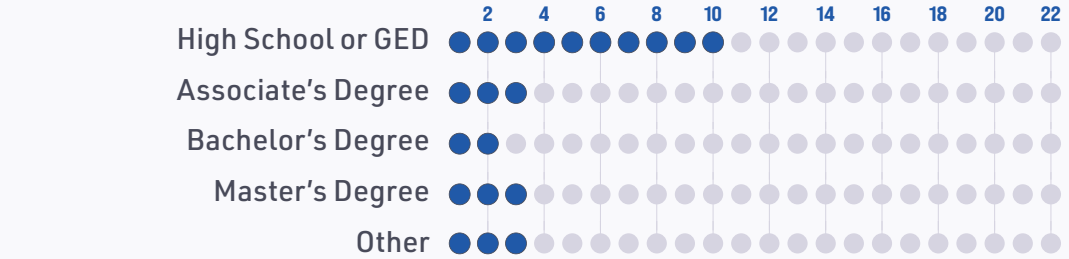
20 people typically spoke **English** at home

ETC appears to have been accessible to people with diverse racial and educational backgrounds, but could be more accessible if offered in Spanish or other languages.

↗ Were racially similar to Oregon's rural/frontier population*



↗ Had diverse educational backgrounds



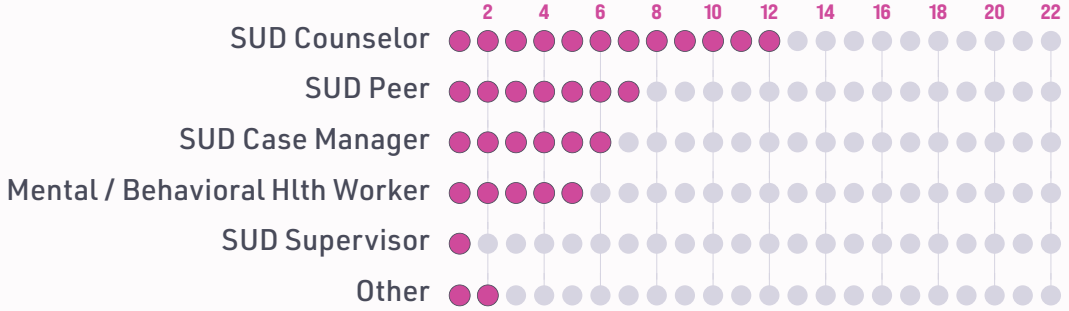
ETC presented a career development opportunity for the SUD workforce, especially those newer in their employment.

↗ Relatively new in current employment

Average length of current employment

2.6 years

↗ Largely employed in an SUD role



*Respondents could select more than one category

Appendix L: Core Peer Training Follow Up Survey Infographic

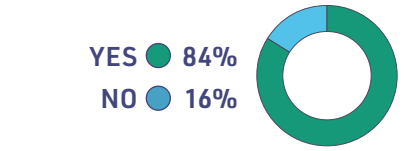
Core Peer Training Follow-Up Survey

The Mental Health and Addiction Board of Oregon (MHACBO) used State Opioid Response Grant funds from the Oregon Health Authority (OHA) to provide the OHA-approved Core Peer training program at no cost to participants. The training fulfills the education requirement for Certified Recovery Mentor (CRM) and Peer Support Specialist (PSS) credentials. The 40-hour training was offered in both English and Spanish languages. OHA contracted with Portland State University to follow up with participants who completed the Core Peer training to evaluate the impact it had on their careers. There were 112 survey respondents, who, on average, completed the survey 9 months after the training.

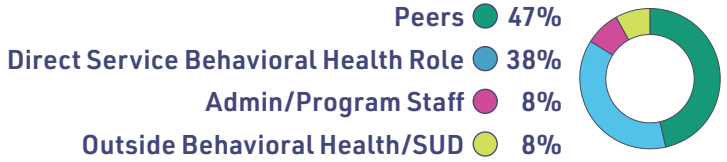
Oregon Health Authority | Portland State University | MHACBO

Most participants were employed, and nearly half were in a peer role.

Currently employed (n=105)

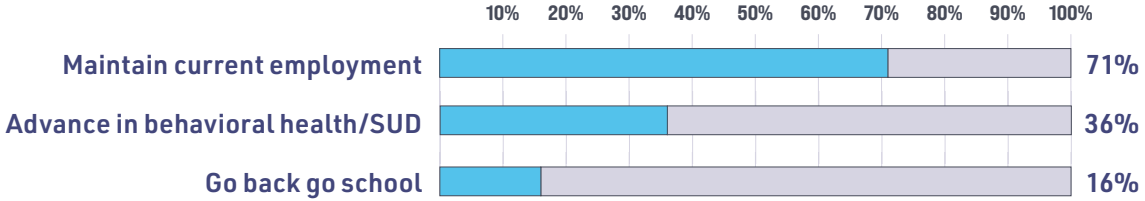


Current role (n=88)



Most participants planned to stay in their current employment in the next year.

Top 3 employment plans for next year (n=103)



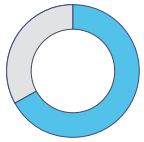
More people are now certified to work as peers.

After training...

(n=107)

The average amount of time since taking training was 9 months

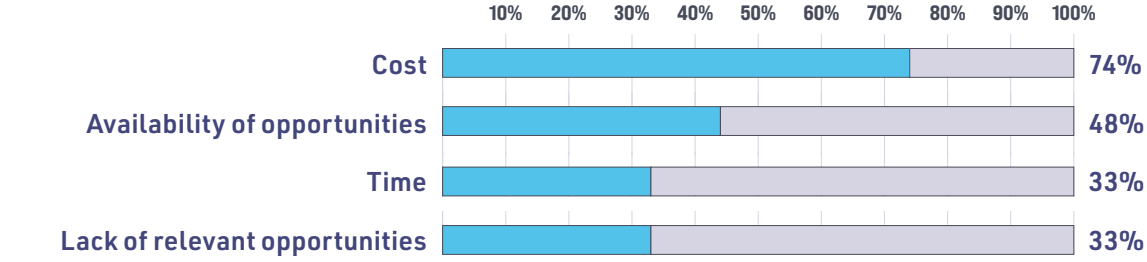
75% earned a **NEW** peer certification after training (CRM, PSS or Peer Wellness Specialist)



67% earned a peer certification for the **FIRST TIME** after training

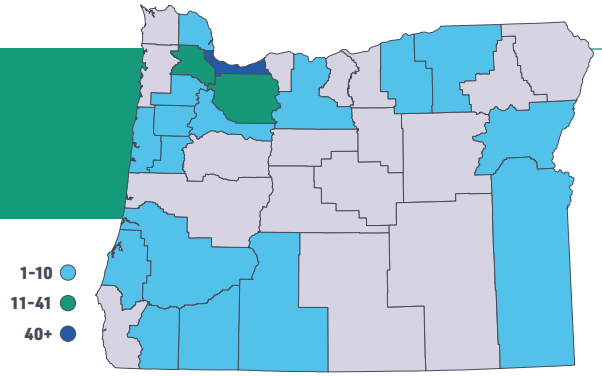
Participants were certified, but 31% had concerns about maintaining continuing education requirements needed for recertification.

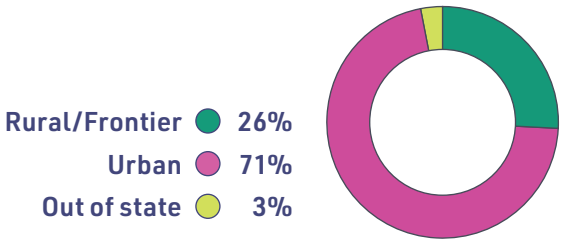
Top concerns about maintaining continuing education for recertification (n=33)



The Peer Core training reached the rural/frontier workforce.

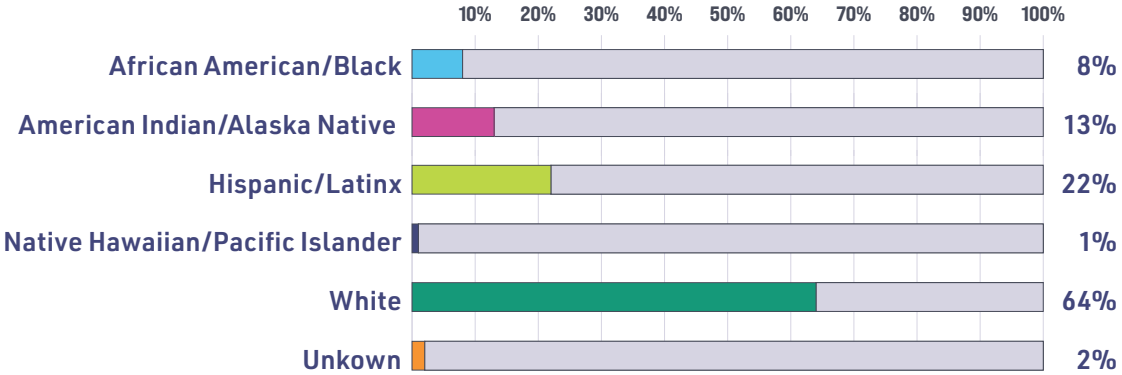
Where respondents work or desire to work, by number of respondents (n=106)



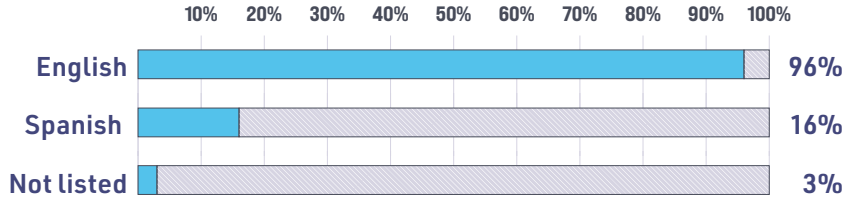


Participants were more racially diverse than Oregon's population, evidence of equitable access to training.[1]

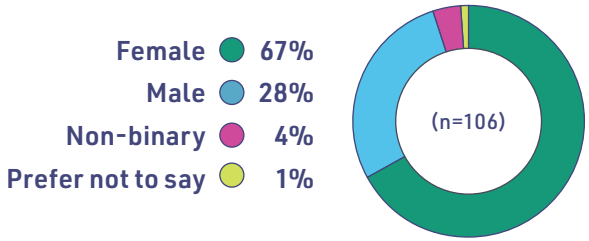
Racial and ethnic background* (n=106)



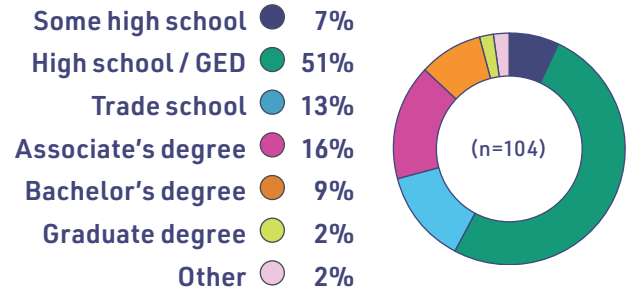
Languages typically spoken at home* (n=103)



Participants largely identified as female.



Training reached people with diverse educational backgrounds.



1. Oregon population comparison data obtained from Rural Health Information Hub, https://www.ruralhealthinfo.org/data-explorer?id=183&state=OR

*Respondents could select more than one answer

Appendix M: Informe de la encuesta de seguimiento de la capacitación básica entre pares Infografía

Encuesta de seguimiento de la capacitación básica entre pares

La Autoridad de Salud de Oregon (OHA) usó el subsidio destinado a la Respuesta estatal a los opiáceos para financiar la Capacitación básica entre pares de la Junta de Certificación de Salud Mental y Adicciones de Oregon (MHACBO), que proporciona la educación obligatoria para obtener las credenciales de mentor de recuperación certificado (CRM), especialista en apoyo de pares (PSS) y especialista en bienestar de pares (PWS). La capacitación de 40 horas se ofreció en inglés y en español. La OHA contrató a la Universidad Estatal de Portland para que hiciera un seguimiento con los participantes que completaron la Capacitación básica entre pares a fin de evaluar el impacto que tuvo en sus carreras profesionales. Hubo 112 encuestados, que, en promedio, completaron la encuesta 9 meses después de la capacitación.

Oregon Health Authority · Portland State University · MHACBO

Más personas cuentan ahora con la certificación para trabajar como pares.

Después de la capacitación... (n=107)

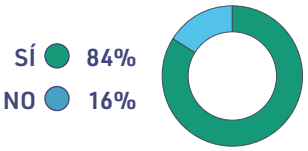
La cantidad promedio de tiempo desde que tomó el entrenamiento fue de 9 meses

el **75%** obtuvo **UNA NUEVA** certificación de pares después de la capacitación. (CRM, PSS or Peer Wellness Specialist)

el **67%** obtuvo una certificación de pares por **PRIMERA VEZ** después de la capacitación.

La mayoría de los participantes tenían empleo y casi la mitad tenían una función de par.

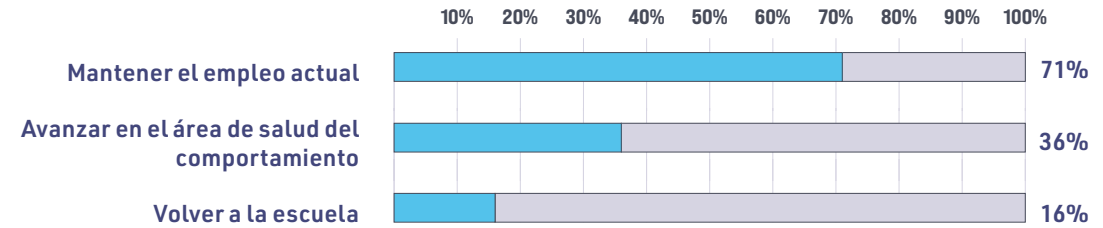
Actualmente tiene empleo (n=105)



Función actual (n=88)

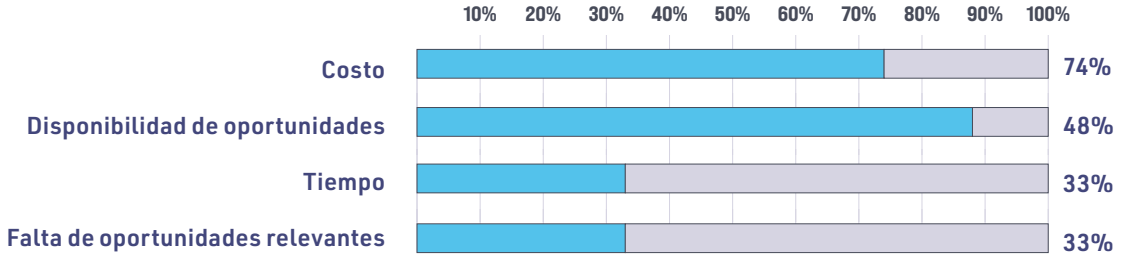
La mayoría de los participantes tenían previsto quedarse en su empleo actual el próximo año.

Los 3 principales planes de empleo para el próximo año (n=103)



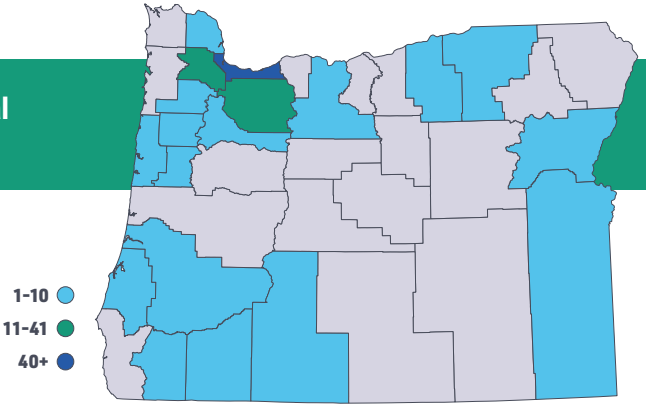
Los participantes estaban certificados, pero el 31 % tenían inquietudes con respecto a cumplir con los requisitos de educación continua necesarios para la recertificación.

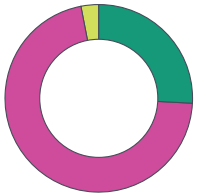
Principales preocupaciones sobre el mantenimiento de la educación continua para la recertificación (n=33)



La capacitación básica entre pares llegó al personal de áreas rurales/fronterizas.

Lugar donde los encuestados trabajan o desean trabajar, según la cantidad de encuestados (n=106)

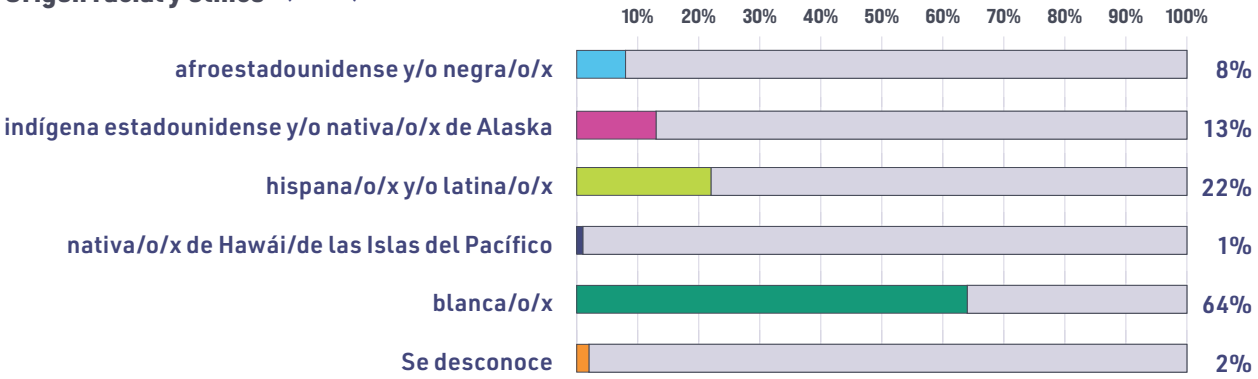




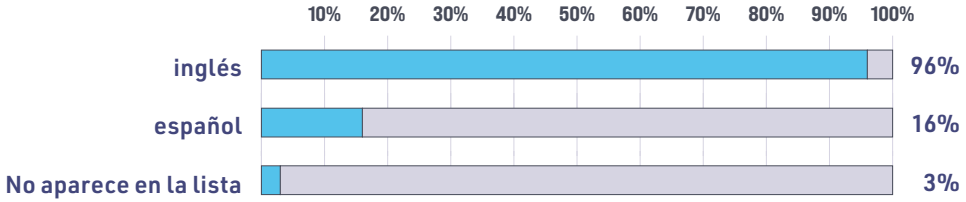
Área rural/fronteriza 26%
Área urbana 71%
Fuera del estado 3%

Los participantes tenían una mayor diversidad racial que la población de Oregon, lo que demuestra un acceso equitativo a la capacitación.[1]

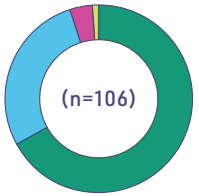
Origen racial y étnico* (n=106)



Idiomas que se hablan generalmente en el hogar* (n=103)

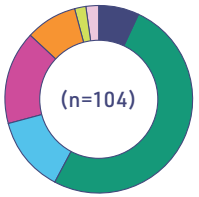


Los participantes se identificaron en gran medida como mujeres.



Mujer 67%
Hombre 28%
No binario 4%
Prefiero no decir 1%

La capacitación llegó a personas con diversos antecedentes educativos



Algo de escuela secundaria (preparatoria) 7%
Preparatoria/Desarrollo Educativo General (GED) 51%
Escuela de oficios 13%
Título universitario de dos años 16%
Licenciatura 9%
Título de posgrado 2%
Otro 2%

1. Datos de comparación de la población de Oregón obtenidos de Rural Health Information Hub, https://www.ruralhealthinfo.org/data-explorer?id=183&state=OR

* En este informe utilizamos categorías de identidad racial/étnica "a/o/x" en un esfuerzo por utilizar un lenguaje neutral en cuanto al género. Los encuestados podían seleccionar más de una respuesta.

Appendix N: Infectious Disease Protocols in MAT Agencies: Key Findings & Recommendations

Infectious Disease Protocols in MAT Agencies: Key Findings

Assessment

- Most agencies receive non-specific infectious disease risk assessment prompts through their Electronic Health Record (EHR) with all client intake encounters. One has adapted the OHA risk assessment tool and two have no prompts for risk assessments, relying on an entirely human-driven process.
- Most agencies focus on HCV and/or HIV in their routine assessments. Most grantees also assess for syphilis, though few do so routinely. A few grantees assess for hepatitis B, though only one does so routinely. Grantees also assess for hepatitis A, gonorrhea, chlamydia, trichomoniasis, and tuberculosis.
- Agencies typically assess for risk at intake. Some grantees also often assess for risk at critical incidents and sometimes annually.
- All agencies receive at least limited reimbursements for assessments, though for several, the reimbursement is just part of the flat rate fee for services received for each client.

Testing and/or referrals for testing

- Most grantees do not have onsite infectious disease testing; they refer to primary care providers, local health departments, or community-based organizations (e.g., HIV Alliance). Two agencies routinely provide onsite testing for at least one infectious disease at intake, critical incidents, and/or annually.
- Half of the grantees routinely test or refer clients for HCV, HIV, and syphilis testing. A couple agencies routinely test or refer clients for other types of infectious diseases (e.g., HPV, gonorrhea, chlamydia)
- All agencies provide at least some coordination, navigation, and/or transportation support to clients to get tested for infectious diseases. Often transportation support is provided informally by peers.
- Most agencies offer some level of onsite infectious disease counseling, though not necessarily by a licensed clinician.

Treatment and/or referrals for treatment

- Blackburn Center can treat most, if not all, infectious diseases in house but can also refer clients to the Multnomah County Health Department for HIV treatment if needed. All other grantees refer clients for infectious disease treatment, most commonly to the local health department.
- Mid-Columbia Center for Living (MCCFL) refers clients to Portland, at least an hour away from their closest location in Hood River, for HIV treatment.
- Two grantees mentioned a culturally specific treatment center as a referral option for infectious diseases (Virginia Garcia Memorial Health Center).
- Some grantees were uncertain where to refer clients for infectious disease treatment.
- Most grantees provide some form of care coordination or navigation support for infectious disease treatment.

Prevention, education, and other supports

- Most grantees provide education on HCV and HIV, and three provide education on syphilis.
- All grantees provide information on harm reduction (i.e., safer drug use including fentanyl test strips, syringe services, PrEP for HIV, and Naloxone), and some provide information on safer sex, and referrals to community partners who can provide additional education.
- Grantees are mixed in terms of whether and when they encourage clients to get hepatitis A or B vaccinations and providing referrals to local health departments. Two provide hepatitis B vaccinations on site and one also provides vaccinations for hepatitis A onsite.
- Three grantees connect clients to financial resources for treatment.

Training

- Only Medford Treatment Center (MTC) provides ongoing training that includes infectious diseases. They have monthly all-staff meetings with training on specific topics, some have been on infectious diseases.
- Most other grantees mentioned standard human resources onboarding training or annual training but no additional infectious disease training.

Summary of current infectious disease services

- Two grantees (Fora, HRBR) provide MAT bridge services in that the goal is to facilitate MAT induction and then connect the client to a long-term provider, preferably a primary care provider who can also test for and/or treat infectious diseases.
- One agency (Blackburn Center) is providing routinized cascade of care services from assessment to treatment for multiple infectious diseases.
- One agency (MTC) is providing routinized syphilis assessments, testing, and referrals to treatment.

- Three grantees (MCCFL, New Directions, HRBR) are providing routinized assessments and referrals for testing for at least one infectious disease. All three of these agencies also provide some level of care coordination for testing and MCCFL and New Directions also provide coordination support for treatment services.
- Three grantees (Best Care, Fora, Willamette Family) are in the initial phases of developing infectious disease services. Of these three, Best Care has drafted protocols for providing assessments and Fora and Willamette Family have described exploring next steps. All three describe nonformal activities and supports for infectious disease services.

Plans

- Three agencies (Blackburn, MCCFL, HRBR) indicated they had no plans to add additional infectious disease services to their repertoire.
- Four grantees (Fora, MTC, New Directions, Willamette Family) indicated they are considering adding risk assessments for additional diseases related to reproductive health (e.g., HPV, gonorrhea, chlamydia, etc.).
- Additionally, Best Care is considering adding assessments for syphilis and Fora is considering adding assessments for COVID-19.
- Willamette Family is considering making risk assessments routine.

Reimbursements

- Facilities that include medical care seem to have the fewest problems with reimbursements overall. One grantee (Blackburn) is a Federally Qualified Health Center, ensuring federal funding for these services. Blackburn Center also has a pharmacy on site that is a 340B pharmacy, supporting discounted medication.
- Three grantees (Fora, MCCFL, and New Directions) receive a flat rate for services per person and so infectious disease supports are included in the flat rate. A few grantees described using billing codes for reimbursements and identifying an appropriate code for the service has been difficult for most.

Challenges & Recommendations for Improving Infectious Disease Protocols

Support grantees in developing their infectious disease policies and protocols.

Grantees would like support for planning more formalized infectious disease services and would benefit from expert consultation from someone who has experience developing these systems and is familiar with Oregon's healthcare system. Moreover, grantees would like to better understand or see updated Oregon Administrative Rules (OARs) on providing primary care services within a behavioral health clinic.

Additionally, grantees are familiar with some best practices for providing infectious disease services in an MAT setting, but they would like support for developing protocols. For example, emerging best practices for integrating infectious disease services into Opioid Treatment Programs (OTPs) include

offering "opt-out" assessments and testing (or referrals for testing) for all clients at intake.[20] This was described as a yet unrealized goal at the Blackburn Center. Another example is the emerging understanding of the importance of peer support workers (e.g., Peer Support Specialists, CRMs).[21] Though peers are included in MAT services, they are not formally included in infectious disease services at most agencies. Grantees could use support developing protocols for and clarifying the peer role in supporting client engagement, education, service access, and retention.

Grantees may also benefit from support in identifying ways to help clients with follow through. Clients are not always interested or able to get tested for infectious diseases, especially during early recovery. Peers can help educate, motivate, and navigate but many clients who inject drugs have damaged veins and can be fearful of other people attempting to draw blood. One grantee suggested offering gift cards as incentives to getting tested. Using Dried Blood Spot tests would also support clients who have been traumatized by having blood drawn from damaged veins.

Support for hiring and resources for ongoing staff training.

The inability to hire and fully staff programs has been an impediment for providing MAT as well as implementing or expanding any infectious disease services. Additionally, grantees would like ongoing infectious disease training and informational pamphlets and other educational resources they could share with clients.

Provide technical assistance and funding to help grantees update their data management systems.

Grantees need support to develop their data management systems to provide their infectious disease services (e.g., reminders, tracking for screening, referrals, and follow up). Ideally, EHRs support tracking and reminders, but some agencies' EHRs are focused on behavioral health rather than physical health and are too antiquated to update. Some agencies have updated their EHRs but still need specialists to help ensure the EHR accommodates their array of services.

Provide training and consultation on billing codes and coordinating with Coordinated Care Organizations.

Grantees providing behavioral health services are not necessarily versed in medical billing codes. Training and support in this area would be helpful. The Coordinated Care Organizations (CCO), which oversee Medicaid reimbursements, are also navigating new territory with behavioral health providers integrating medical care. Important to note, the CCO designation of behavioral health clinic or medical clinic has created a barrier to implementing infectious disease services due to CCO policies around payments for these services. Some grantees have been able to work with CCOs to ensure their infectious disease services satisfy requirements for billing, but grantees would like support for coordinated collaboration with CCOs.

[20] Addiction Technology Transfer Center Network Coordinating Office, A Guide to Integrating HCV Services into Opioid Treatment Programs, July 2020.
[21] Ibid.

Help grantees identify and collaborate with testing and treatment providers.

Some grantees have formal arrangements with testing and treatment agencies that support client connections to care but most need support in this area. Grantees don't always know where to refer clients for infectious disease services. In terms of collaboration, grantees would benefit from training on how to develop MOUs and using tools such as DocuSign for electronically signing releases of information. Furthermore, it can be challenging to work with multiple labs because they often use different terminology for their tests, which necessitates up-front coordination to ensure testing requests are correct. Development of consistent language across labs would mitigate this issue. Another suggestion is a state-run lab, which would reduce the need to contract with multiple labs and support grantees to integrate infectious disease services into their service array. Lastly, assisting grantees in building relationships with pharmacies would help ensure clients continue treatment because pharmacies track when medication is dispersed.

Target people who inject drugs in public health campaigns for using PrEP to prevent HIV infection. Some grantees encourage clients who are eligible (e.g., not HIV positive, good kidney function) to take PrEP for preventing HIV infections; however, many clients decline. The marketing around PrEP often targets gay men, a high-risk community for HIV infection. People who inject drugs (PWID) sometimes assume that PrEP is only for this community. Targeting PWID in public health campaigns for PrEP could increase the use of this medication and prevent HV infection.

Appendix O: SOR2 Grantees

Grantee/Program	SOR2 Strategic Goal Area(s)
Save Lives Oregon/Naloxone Clearinghouse	HR/ODP
Clatsop County Public Health	HR/ODP
HIV Alliance	HR/ODP
Max's Mission	HR/ODP
Multnomah County Health Department	HR/ODP
Outside In	HR/ODP
BRINK/Save Lives Oregon	HR/ODP
Comagine/PRIME+	HR/ODP
Recovery Link/PRIME+	HR/ODP
Coquille Tribe	UP, TX, R
Burns Paiute Tribe	UP, TX
Confederated Tribes of Coos, Lower Umpqua & Siuslaw Indians	UP, R, HR/ODP
Cow Creek Band of Umpqua Tribe of Indians	UP, TX, HR/ODP
Confederated Tribes of the Grand Ronde	TX
Klamath Tribal Health & Family Services	UP
Confederated Tribes of Siletz Community Health Clinic	TX, HR/ODP
Yellowhawk Tribal Health Center	TX
Confederated Tribes of Warm Springs – Warm Springs Behavioral Health	UP
Native American Rehabilitation Association of the Northwest	UP, TX, R, HR/ODP
Lines for Life/Tribal Opioid Summit	UP, WFD
Lines for Life/OPAT Conference	UP, WFD
Lines for Life/Strategic Planning Initiative	UP
Rede Group/Coordinated Youth Serving Systems	UP
Oregon Department of Education	UP
Drug Overdose Prevention Initiative	UP
Change Management/Oregon Pain Management Commission	UP, WFD
Comagine Public Health Collaboration	UP
UNR/Region 10 Opioid Summit	UP, WFD
BestCare/MAT	TX
Central City Concern- Blackburn Center/MAT	TX
Fora Health Hillsboro Outpatient/MAT	TX
Mid-Columbia Center for Living/MAT	TX
OHSU HRBR Clinic/MAT	TX
Mind Solutions/MAT	TX
Willamette Family/MAT	TX
Medford Treatment Center/MAT	TX
New Directions NW/MAT	TX

Grantee/Program	SOR2 Strategic Goal Area(s)
Oregon Recovery Treatment Center/Engagement and Outcomes Solutions	TX
Oregon Recovery Treatment Center (Grants Pass, Medford, Springfield)/CM	TX
Comagine/Nurture Oregon	TX
Oasis/Nurture Oregon	TX
ReConnections Alcohol and Drug Treatment Inc/Nurture Oregon	TX
OHSU/Nurture Oregon	TX
4th Dimension Recovery Center	R, HR/ODP
NW Instituto Latino	R, HR/ODP
Painted Horse Recovery	R, HR/ODP
Alano Club of Portland	R
Miracles Club	R, HR/ODP
Oxford House	R
Greater Oregon Behavioral Health, Inc.	R
ACT NW/Harmony Outreach Coordinator	R
Harmony Academy	R
MHACBO Peer Workforce Development	WFD
Janis Crawford LLC	WFD
Dental Project ECHO	WFD, UP
Project ECHO	WFD, UP
OHSU Hepatitis C Treatment/PATHS	WFD
Northwest ATTC/Contingency Management	WFD, TX

Key:

HR/ODP = Harm Reduction/Overdose Prevention
TX = Substance Use Disorder (SUD) Treatment
R = Recovery
UP = Upstream Prevention
WFD = Workforce Development

Appendix P: Collaboration Codes and Definitions

Table 1. Collaboration Types: Codes and Definitions

Code	Definition
Informal: Networking/ Cooperation	Agencies aware of each other; informal interactions; mutual support with no specific shared goals; info sharing. Mostly informal communication and information sharing; do not necessarily have the same mission or goals; somewhat defined roles; independence. *Note:* Excluded activities that were clearly 1-way where "end user" is unknown (i.e., distributing flyers, advertising services to an unknown audience)
Semi-Formal: Collaboration	Semi-formal relationships; voluntarily shared resources; frequent communication; specific roles; shared ideas and decision making; shared mission/goals; independence.
Formal: Outsourcing/ Integration	Contractual relationship in which one organization agrees to have another carry out specific functions or tasks. Joint venture; formal relationships (contract, MOU); interdependence; frequent communication; mutual trust; contracted/allocated shared resources; ongoing planning; joint decision making.
Unable to determine	Not enough information to determine the types of collaboration associated with SOR2 funded activities.

Table 2: Effects of Collaboration: Codes and Definitions

Code	Definition
Changes in member organizations *(group involved in collaboration)*	Changes in policies, efficiency, culture, or communication flow (frequency, type, regularity) due to collaborations. *If NOT a workforce grantee*: Grantees training people at other organizations (e.g., harm reduction grantees) could result in staff capacity/PD changes for their staff.
Changes in staff capacity and/or professional development	Changes in the grantee's staff including recruitment, hiring, training, increasing skill/knowledge, certifications.
Changes in service capacity	Changes in service availability and utilization due to collaborations: More services available, utilized more (or less) frequently, less redundant across organizations. Incoming referrals might be an indication of increased service capacity. *Workforce grantee*: service capacity = more training available/trainees
Changes in service quality	Changes in service quality due to collaborations: Improved timeliness, coordination/referrals to other services, and appropriateness of service; improved quality of service provided to the target population. *Workforce grantees*: service quality = quality of training
Participant outcomes	Changes in the lives/outcomes of the target populations due to collaboration (access, utilization). *Workforce grantees*: target population = training participants/practitioners
Community outcomes	Changes in the larger community (public; beyond individuals in the target populations) due to collaborations. Community could be neighborhood, city, region (distinguishing this from participant outcomes). *Workforce grantees:* target population = training participants/practitioners
Community perceptions	Changes in perceptions of the community, the public, funders, or other decision makers from collaborations. *Sub-codes*: Community/public, Funders/decision makers
System change	System change/innovation; innovative ideas or processes worth highlighting; strengthening the local (or statewide) system of care (e.g., availability of resources/referral pathways); significant number and/or variety of pathways/influence on system.
Unknown	Not enough information shared to assess effects of collaboration; no clear link from collaboration to outcomes.

Table 3: Types of Organizations: Codes and Examples

Organization Code	Examples
SUD Provider	Treatment provider, recovery organization
Local or county government	Local public health authority, City, County, governmental entity
Behavioral/Mental Health Provider	Therapy, case management, peer services (outside of SUD services)
Physical Health Organizations	Hospital, health clinic
Community Organizations	Religious institutions, service providers outside of SUD/MH (e.g., housing)
Judicial system	Law enforcement, prison/jail
First responders	Fire department, Emergency Medical Technician (EMT)
Oversight	Oregon Health Authority, Coordinated Care Organizations, policy makers, Oregon Department of Education (e.g., regulations, funding, power, decision-making)
Academic/Research institutions or Professional communities	Universities, colleges, evaluators, professional organizations, professional learning communities
Child welfare system	Child protective services, foster care
Culturally specific	Could overlap with one or more of the above, includes tribes
Peers	Organization that employs peers (people with lived experience)

Appendix Q: Collaboration Questions from Three Progress Reporting Periods

Reporting period		Collaboration question
Year 1 mid-year		Describe the collaborations and community partnerships developed/created and how these have affected your ability to carry out SOR2-funded activities.
		Describe how you are working (or plan to work) with culturally-specific communities (e.g., communities of color, youth, rural/frontier, etc.).
Year 1 end-of-year		Describe any NEW collaborations or community partnerships that you have developed in the past six months as part of carrying out SOR2-funded activities.
		Thinking about ALL your collaborations or partnerships, which have been most significant in terms of your ability to carry out SOR2-funded activities? Why?
		How are you intentionally working to be more inclusive of culturally-specific communities in your SOR2-funded activities (communities of color, LGBTQ, youth, rural/frontier, immigrant/refugee, etc.)?
Year 2 mid-year	Year 2 grantees/ programs	Describe the collaborations and community partnerships developed/created and how these have affected your ability to carry out SOR2-funded activities.
		How are you intentionally working to be more inclusive of culturally-specific communities in your SOR2-funded activities (communities of color, LGBTQ, youth, rural/frontier, immigrant/refugee, etc.)?
	Year 1 grantees/ programs	Describe any NEW collaborations or community partnerships that you have developed in the past six months as part of carrying out SOR2-funded activities.
		Describe any NEW or EXPANDED ways you are intentionally working to be more inclusive of culturally-specific communities in your SOR2-funded activities (communities of color, LGBTQ, youth, rural/frontier, immigrant/ refugee, etc.)?

Appendix R. SOR Evidence of Impact Rubric Dimensions and Definitions

Conceptual Group	Dimension: Definition	Rating (Code Value)			
		Evidence of harm (-1)	**No evidence (0)**	**Some evidence (1)**	**Clear evidence (2)**
Impact	**Validity:** Strength of link between SOR2-funded activity and outcome, or degree of confidence that outcome resulted from SOR2-funded activities	N/a	No information; No way to determine whether SOR2 activity produced the outcome	Outcome might be due to the SOR2 activity but many plausible alternative explanations.	The outcome is clearly due to the SOR2 activity and most or all alternative explanations can be ruled out.
Impact	**Magnitude of effect:** Size of the impact of SOR2-funded activity	Activity produced a harming effect or negative outcome.	No information; No way to determine magnitude of effect (i.e., outcome not measured); activity did not result in desired outcome.	Activity had small effect (nearly or met benchmark; small practical or clinical effect) or mixed effects (more negative or null than positive) on outcome; not enough information to code as "clear evidence."	Activity had a moderate to large effect (met or exceeded benchmark; medium-large practical or clinical effect). If mixed, more positive than negative or null effects on outcome.
Impact	**Relevance of outcome:** Importance or relevance of outcome produced by SOR2-funded activity to policy, practice & community	A negative or unintended side effect or consequence.	No information; No way to determine relevance or importance; outcome not measured; measured outcomes that were not relevant to SOR2, SUD policy or practice, or communities.	Activity measured & showed at least some impact on outcomes that were relevant or important to SOR2, SUD policy or practice, or communities; very limited relevance/ importance information provided.	Activity measured & showed impact on outcomes that were relevant or important to SOR2, SUD policy or practice, or communities; strongly relevant/important.

Conceptual Group	Dimension: Definition	Rating (Code Value)			
		Evidence of harm (-1)	**No evidence (0)**	**Some evidence (1)**	**Clear evidence (2)**
Transparency	**Target group:** Description of the target group involved in the SOR2-funded activity	N/a	No description (or very vague; only one descriptor - e.g., "adults" or "high school teachers")	Limited/basic description of target group involved in the activity; minimal description of group(s) represented in evaluation/data collection activity.	At least moderately detailed description of target group involved activity; detailed description of group(s) represented in evaluation/data collection activity.
Transparency	**Intervention or activity:** Description of the SOR2-funded activity	N/a	No description of intervention or activity.	Limited/minimal description of intervention or activity; unknown dosage.	At least moderately detailed description of activity; specific/known dosage or prescribed program.
Transparency	**Context:** Description of the relevant context in which SOR2-funded activity is carried out	N/a	No description of the relevant context & how it impacted outcomes	Limited/minimal description of the relevant context & how it impacted outcomes.	At least some/more robust description of the relevant context & how it impacted outcomes.
Transparency	**Limitations:** Discussion of limitations of the data collected, information shared, or evaluation methods used	N/a	No discussion of: limitations of methods; alternative explanations for outcomes reported; reasons for null or negative findings.	Limited/minimal discussion of: limitations of methods; alternative explanations for outcomes reported; reasons for null or negative findings.	At least some discussion of limitations of methods; alternative explanations for outcomes reported; reasons for null or negative findings.
Equity	**Access:** Assessment of whether access to SOR2-funded activity is equitable	Activity excluded (not available) known marginalized groups; activity not successful in including marginalized groups	No information about access of intervention or activity to marginalized groups.	Activity had limited success in ensuring access (making available); included 1-2 marginalized groups or minimal efforts with a group.	Activity had at least moderate degree of success in ensuring access (making available); included a range of marginalized groups or extensive efforts with a group.

Conceptual Group	Dimension: Definition	Rating (Code Value)			
		Evidence of harm (-1)	**No evidence (0)**	**Some evidence (1)**	**Clear evidence (2)**
Equity	**Constituent driven:** Description of whether/how consumers, clients, people with lived experience, etc. were involved in the development of the SOR2-funded activity	Constituents denied involvement in the development activity (no effort made); or despite efforts made, constituents not involved	No information about constituent's involvement in the development of the activity.	Constituents had limited involvement in the development of the intervention or activity (research, planning, advisory roles). E.g., Input or feedback that is unidirectional.	Constituents had at least moderate involvement in the development of the intervention or activity (co-creation, research, planning, advisory roles) E.g., some type of reciprocity or responsiveness.
Equity	**Services received:** Assessment of whether those receiving/involved in SOR2-funded activity had equitable services	Certain groups received less or inferior quality activity	No information; no evidence suggesting effort to understand differences.	Some evidence of cultural competence in intervention or activity; minimal evidence of awareness of barriers to treatment, work to reduce or remove barriers.	Culturally responsive, culturally specific intervention or activity; moderate to strong evidence of awareness of barriers to treatment, work to reduce/remove barriers.
Equity	**Outcome:** Assessment of whether the outcomes of SOR2-funded activities were equitable	Activity harmed specific groups (e.g., marginalized, priority populations); perpetuated known disparities.	No information; no evidence suggesting effort to understand differential impact.	Activity made small reductions in known disparities	Activity made at least moderate reductions in or eliminated known disparities.
Equity	**Constituent experience:** Effectiveness or impact of SOR2-funded activity assessed using perspectives from consumers, clients, or people with lived experience.	N/a	No information; no evidence of efforts to include constituent experience or perspective.	Limited effort made to measure constituent experience, or not systematic.	At least moderate effort made to measure constituent experience (e.g., client survey, interviews, systematic data collection, CQI).

Conceptual Group	Dimension: Definition	Rating (Code Value)			
		Evidence of harm (-1)	**No evidence (0)**	**Some evidence (1)**	**Clear evidence (2)**
Equity	**Addressing institutional & personal bias:** Description of how SOR2-funded organization addresses institutional and personal bias	Constituents experienced harm.	No information about organizational/personal anti-bias work (e.g., policies, referral mechanisms, training)	Efforts made a limited difference in org/personal bias.	Efforts made at least a moderate difference in org/personal bias.

Appendix S. Key Availability & Utilization Outcomes

Availability Outcomes	Examples
Expanded overdose prevention services	– Emergency response services – Naloxone kits purchased & distributed
Increased harm reduction resources to people with SUD	– Syringe exchange services
Increased opportunities for learning and workforce development	– Resources for middle school health educators aligned with state standards – Organizations receiving training/TA about the Harm Reduction Clearinghouse – People trained to use Naloxone – Community events held to increase awareness of overdose training and Naloxone – Culturally and linguistically appropriate training in harm reduction services
Increased infectious disease testing, treatment, and preventative care	– HIV/HCV testing – Hepatitis A and B vaccinations
Expanded opportunities for treatment	– Project Nurture services – Rapid access to MAT services – Equitable access to treatment services – Culturally responsive services
Increased access to client information	– Availability of RecoveryLink reporting resources
Increase resources for implementing strategic plans	– Implementation of an integrated model for providing a full continuum of addiction treatment & recovery services
Expanded availability of recovery services	– Equitable access to recovery services – Culturally-specific recovery resources
Utilization Outcomes	**Examples**
Increased use of harm reduction supplies or services	– Using Naloxone or Narcan – Overdose reversals – Syringes exchanged
Increased use of infectious disease testing, treatment, and vaccination	– People tested for HIV/HCV and referred for treatment – People vaccinated for Hepatitis A and B
Increased use of recovery services	– Client satisfaction with recovery services – Participation in recovery services with Certified Recovery Mentor – Clients' quality of life/work/education

Utilization Outcomes	Examples
Increased use of treatment services	– Client engagement & retention in MAT services – Equitable treatment outcomes – Satisfaction with treatment services – Continued SUD treatment after MAT induction – Decreased substance use – Client participation in Project Nurture services
Increase uptake of learning opportunities in SUD workforce	– Participants completed training – Participant satisfaction with training or conference – Demonstrated skill proficiency for Contingency Management